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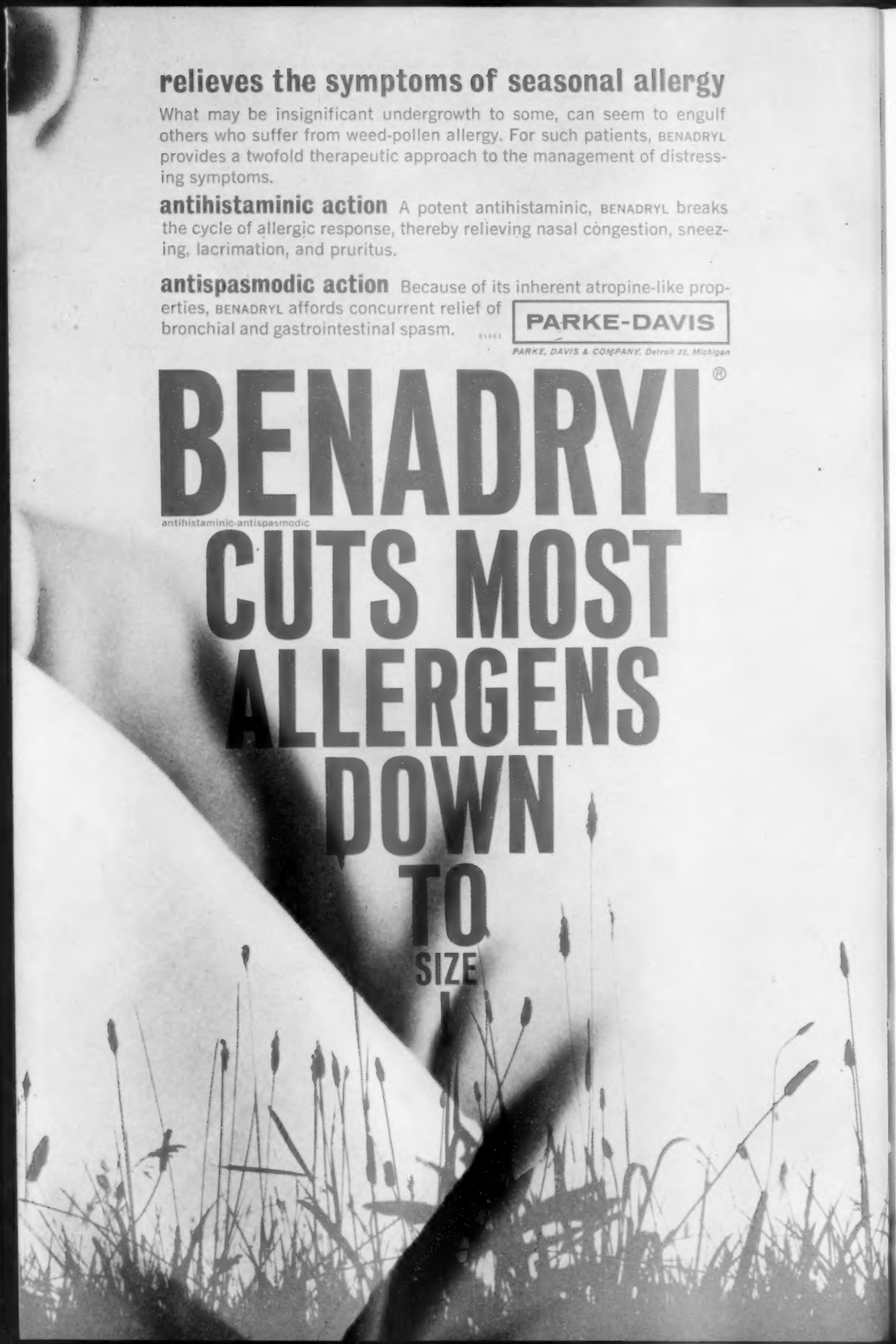
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*The Social Security Sputnik and Organized Medicine**

RECENTLY A POLL WAS TAKEN of the Dade County Medical Association which showed that 56 per cent of our members favored compulsory Social Security for physicians. As Chairman of their legislative delegation, I am duty bound to make this fact known to all Florida and, if possible, our national councils. It is with a heavy heart and a sense of guilt that I do so. Doctors when presented with sufficient fact have judgment second to none. Few of them, however, have the time to keep informed on matters of economics, and an even smaller number is interested in political methodology. Those of us who are interested, and informed, have a duty to communicate, and this article is an attempt at such communication, in which I have been so remiss.

First and foremost, I feel that compulsion of itself is an evil thing. I have no quarrel with those who want Social Security for themselves, but I do not feel that they should try to force it upon me, any more than they should try to make me drive a Cadillac when I am content to drive a Volkswagen.

I cannot argue successfully that Social Security, if continued as it is presently constituted, would not be financially advantageous for certain of the older age groups. Indeed, it has been the custom to add additional benefits to recipients from time to time without their having to pay for them at all. Our politicians would have us think of a return of $17 for 50 cents as an example of tender loving care. To me, it is simply an example of complete actuarial irresponsibility. Most of us as physicians have paid enough income taxes to finance our senescence in luxury and many times over. Some of the older may try to justify their acceptance of such monies on this ground. I do not believe that even the aged in our profession would want to profit unjustly at the expense of their younger compatriots.

For the younger or middle-aged physician to embrace Social Security willingly is to me unthinkable, because:

1. You are voting for a second Income Tax, and the rates are certain to go up. We were told when the Sixteenth Amendment was passed that Income Tax rates would never exceed 10 per cent. At the present, we are being told similar nonsense about Social Security. Even if no additional benefits were added, Social Security reserves (actually monetized debt) total only 27 billion, while liabilities are already in excess of 247 billion. The only possible source of increased Social Security revenue is an increase in Social Security taxes. Similar benefits in France, for instance, are financed by a 34 per cent payroll tax. Income taxes have reached the point of diminishing returns. Higher income tax rates simply mean diminished revenue. Social Security will not be financed by Income Tax money because the money simply is not there. Accordingly, cutbacks or increased Social Security taxes will be mandatory.

2. Social Security is welfare legislation pure and simple, and can be changed by the Congress in any way or at any time it sees fit. In case you are one of those who believe in the infallibility of our Supreme Court, a decision was handed down on June 20, 1960, in the case of Fleming vs. Nestor, which certifies to the fact that Social Security is welfare legislation rather than insurance. If the Government itself says Social Security is not insurance, how can others pretend that it is? The Government issues you no policy. You cannot even name your beneficiary. You have to wait 17 months before the plan becomes operative, and the rather meager stipend which you feel you may possibly draw at some time is *very* stringently qualified. As a matter of fact, you have to swear to live in poverty insofar as professional income is concerned, in order to draw anything at all. I cannot imagine a practicing

*Credit to: Journal of the Florida Medical Association, May, 1961, issue. In the opinion of your editors, this message is a masterpiece of diction. We are indebted to our colleague, Dr. James L. Anderson, for expressing the cause of freedom, not only for our profession, but for all Americans.

physician aged 65, with an income of less than $100 a month, if he goes to his office even for one hour a day. Most of us in this day of increased longevity and health enjoy our work far beyond this rather adolescent age limit. Indeed, for the healthy physician really interested in medicine, it is not insurance in any sense of the word. He would never make little enough to draw it.

3. The original Social Security Act provided that you, or your heirs, would be refunded the amount you paid into this fund. This provision has been removed. Social Security needs a transfusion, and the medical profession, I am afraid, has been selected as a donor.

I suppose, however, that if a doctor of 63 intended to retire at age 65 and never set foot in his office again, if this doctor also felt comfortable about passing his burden of retirement on to the younger generation, and if, in addition, he measured all things, even socialism, in strictly economic terms, it is probable he could profit monetarily. Even at this, however, he might *not* profit, in that all the Congress has to do is to pass a law saying simply, "We don't pay," and that is it. A younger man, fearing imminent disability, might also profit if he happened to fit into some particular category, but this type of protection can be obtained elsewhere; again, a "We don't pay" by the Congress is all that is needed to disallow liability.

In summary, it seems fair to say that older physicians would seem to benefit financially from Social Security as it is presently constituted. Younger physicians are simply voting upon themselves a second unlimited income tax in return for benefits which, while specific to a degree at the present time, can nevertheless be changed, altered, amended or eliminated in accordance with the spirit of the times. At least one benefit has already been eliminated; you no longer can get your money back. A far greater danger is that it will be additionally loaded every election year with so many benefits that chaos will ensue. The alternatives to this chaos are either increased Social Security taxes or diminished benefits. Since the law in itself is socialistic in inception, implementation, and action, it takes little perspicacity to see what will happen.

The higher tax rates will be enormously unpopular. Since the additional revenue cannot be obtained by raising income tax rates, there is but one alternative—a cutback in benefits. Where will this cut be made? The labor unions are too potent politically to be treated roughly, but I can see the newspaper headlines even now, "How can the cruel, aggressive, monopolistic and *wealthy* medical profession insist on receiving a meager stipend, which its members do not need, while the poor but noble workers do not have enough to eat?" The amended law itself can be more subtle, "Recipients of Social Security benefits must not receive more than $1,200 per annum from any source." This is all that would be needed. Shall we as physicians join in the present mad rush toward economic cannibalism and the destruction of America, or shall we continue to remain aloof? I say let others have their Social Security. I prefer to run my own life. May God grant that I be allowed to do so.

JAMES L. ANDERSON, M.D.

Fighting Disease With Ink

AS THE ANCIENT EGYPTIAN worshipped the sun, so our medical culture appears to be centering its focus on a veneration for paper and ink. More and more, the tendency is evident to equate adequacy of procedure in the practice of medicine and its ancillary pursuit, nursing care, with the bulk of the paper work that is generated along the way. At our hospital, in addition to inditing the customary quota of notes, opinions, orders, etc., the doctor is now required to approve with his signature almost every commentary by others that finds its way to the chart. From time to time, under pressure, he countersigns statements and descriptions with which he may be only partially in agreement because he is aware that to ask for a revision before signing would be resented as tending to impede the flow of paper work.

A generation ago, the eager student nurse or graduate nurse accompanied the physician to the bedside and, on the way, recounted last night's vicissitudes and explained the patient's morning status. Today, the doctor is virtually ignored on the division. He arrives to confront the spectacle of six to a dozen

young women in different versions of the nurse's uniform, seated at desks and counters, plying the distinctive present-day tool of their trade—the pen. On interrogation they are not seldom annoyingly vague as to patient so-and-so's temperature or mood or whether he ate his breakfast, or even, on occasion, as to whether a patient of that name even occupies a bed under their jurisdiction. This haziness seems often to cause them little chagrin. As a psychiatrist might say, they appear to feel entirely "adequate" in following the latter-day concept that the crux of nursing care is the inkwell. Why doesn't someone remind the contemporary leaders of nursing education that Florence Nightingale is of blessed memory not because of the volume of her notes but because as the "lady with the lamp" she was ever at the bedside, even in the black of night, to give that comforting personal care and encouragement that is the historic glory of the nursing profession?

We are informed periodically in staff meetings that a national accreditation official has inspected our hospital and approved it. His inspection must be largely one of records and equipment, since very few of my colleagues ever meet him. In spite of assertions to the contrary, we submit that records are no proper basis for judging the competence of clinicians or surgeons. A trained nonmedical journalist, with his skill in using reference books and in weaving word-patterns, might possibly write more convincingly about appendicitis or gallstones than a surgical specialist, but he would be a poor choice to direct a scalpel in your direction. Evaluation of any candidate for membership in, let us say, the American College of Surgeons, involves far more than reading the written account of a prescribed series of surgical operations. To do the job properly, the examiner could do no better than to live with his candidate for days or weeks and watch how discerning and deft is his management of patients' problems.

Present trends in hospital procedure are reminiscent of the monks in Tibet, legions of whom are said to spend their lives inditing prayers on cards, to be mounted on water wheels so that each revolution may propitiate the gods. If one seeks to identify the American gods who must be propitiated by the present fulsome tide of paper work, they are explained as nebulous and multiple authorities in distant places. One senses that he is confronted by a bureaucratic philosophy which tends to base its approval on dull stereotypes—rather than to emphasize those dynamic ideals of personal responsibility and high devotion which are the basis of the doctor's traditional position in the layman's mind.

Coherent medical records are, to be sure, a fundamental need, and on this point we have no intention to start an argument. Obviously, no hospital chart is adequate unless it is easy to find all the relevant data as to the patient's complaint and past medical history, his physical and laboratory findings, the opinions of consultants, and the detail of operative procedures and medications. Likewise, the patient's response to treatment and his condition on discharge should be clearly evident. Any chart found hazy or deficient in these matters is clearly wanting and has no defense.

An example of what irks, however, is the Pharisaism which recently caused our hospital Record Room to reject a highly competent note by one of the best internists in Utah because, inadvertently, he had written it on white paper among the Progress Notes instead of using the pink form designated for Consultations. At Easter time one cannot help being reminded that the hair-splitting "scribes" of the New Testament must have been people like that. R. P. Middleton, M.D.

It's Later Than You Think

TALK ABOUT CREEPING CORRUPTION—specifically how compulsory government medicine, once it is a fact—will gradually lower its age coverage from 65 to 60 to 55 to 50! Our new opinion is it won't be nearly that slow. Not just the government; even the civies are in on the age-lowering act. Our faith in the fine old American tradition, Sears Roebuck and Company, was shook to its foundations a few weeks ago when we read the ads on the vitamin page, to wit:

GERIATRIC VITAMINS—SPECIALLY DESIGNED

Designed especially for people over 35.

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ARTICLES

The fate of the personal factor in medical practice*

Allan L. Haynes, M.D., Clovis, New Mexico

If you have questioned the meaning or vital necessity of the doctor-patient relationship you will want to read every word of Dr. Haynes' analysis.

IT IS MY PURPOSE to consider the fate of the personal factor in medical practice. As an essential part of the patient-physician relationship, its importance in the therapeutic effort has been duly noted and emphasized on many previous occasions. To us as physicians its importance is so obvious and the need for its preservation is so apparent that we are prone to think that there is general public understanding and appreciation of this factor equal to our own. But like all virtues, it is worthy of occasional reconsideration of its intrinsic nature and of its importance in the equation represented by the patient-physician relationship. Let us therefore redirect your thoughts along familiar lines in hope you will bear with my repetitions as I work toward extension of this theme.

The personal involvement of the physician in the ultimate fate of his patient is not only of great value to the patient, but to the physician as well. In every illness of consequence, the patient and the physician are drawn into an increasingly intimate personal association. This is subject to many modifying factors including the personalties of both individuals, their respective philosophies and moral codes, and their ability to express themselves articulately, as well as such more apparent factors as the gravity of the disease, the prognosis, and the complexities and hazards of the treatment. Physicians are sympathetic individuals; in the beginning of their association with each new patient the relationship is essentially that of strangers entering into a joint venture, but, as the process of diagnosis and treatment continues, some degree of mutual understanding and, in all successful cases, of mutual respect and appreciation, must develop. That the patient has something at stake is readily apparent; that the physician has at stake his professional reputation and his means of livelihood is equally apparent. Not so apparent is the fact that the physician soon experiences a strong personal bias in favor of his patient; he has now entered into an intimate personal association in which he is the patient's advisor as well as therapist. He is the patient's source of emotional support, his colleague, and his cohort—he is the patient's champion in the tournament. In the parlance of the sports writer, the physician is now a "rabid rooter" for his patient. The more serious the disease, the more prolonged and difficult the treatment, and the more dubious the outcome, the more pervasive is the physician's personal identification with the well-being of his patient: And all of this with what is now a disregard of any selfish motivations. A challenge has been accepted and the physician's personal sense of adequacy is now at stake in the issue.

*Presidential address presented before the New Mexico Medical Society, May 17-20, 1961, at Santa Fe, N. M.

The value of this personal identification is obviously in the best interest of the patient. The value to the physician in increasing the intensity of his own endeavors is perhaps equally obvious. But there is a further value to the physician that we often overlook. We are, after all, idealists; we have our earnest desire to serve, and we have our own psychologic need for a feeling of adequacy in our own work. Entirely above all selfish advantages accruing in the successful outcome of his treatment, the physician fulfills an emotional and spiritual need within himself when he enters into this physician-patient relationship. Lacking this, he is reduced to the level of a biochemical mechanic, he exists in his own vocation at a level below that which meets his own needs and capacities; a void in his own personality stands empty. Perhaps the best measure of the value to the physician appears in the sense of personal loss when the association ends in the death of a patient. Each of us knows the feeling of personal defeat, of having lost something of great value to ourselves, in each of these instances. As another measure, contrast if you will that feeling of personal success and of personal conquest, the sense of exaltation we feel even if only in a transient moment in our successful results. Here, the physician feels a complete man. To the physician this is an essential spiritual support of his life. I hope, then, that I have demonstrated again to your satisfaction as well as to mine that this personal factor in the practice of medicine is of intrinsic merit for the healer as well as for the sick. There can be no doubt in the minds of experienced physicians that this is a precious personal value to be preserved as long as it is within our power to do so.

Primacy of personal involvement

Now let me direct your thoughts toward the possible future of this elemental spiritual value, this personal factor in medical practice. From the days of the temple at Delhi before Hippocrates, through the Roman and Arabian ascendancies, through the era of the schools at Salerno and Montpellier, through the tumultuous upheavals of the Renaissance and the Enlightenment, the primacy of this personal factor was never questioned, never doubted. If one dates the Industrial Revolution from the mid-eighteenth century onward, even the first hesitant poundings and thumpings of that momentous change in the relation between man and his environment had no immediate effect upon the patient-physician equation. Another 150 years were required before the technologic changes of a more sophisticated science began to impinge ever so slightly upon this personal element. Rather, it was in the round-about fashion of the increasing complexity of society in the Industrial Age that the first threats appeared in the form of Bismarck's socialized medicine in Germany. From that day onward, politically inspired schemes arising from various quarters and from various motivations have posed ever graver threats to this valued quality.

Simultaneously, there have been certain inevitable and, as I regard them, largely irretrievable, losses arising from the successes of modern therapy. The very ease and facility of many of our procedures has so increased the prospect of cure, so shortened the period of illness, has made so automatic some of the processes of modern therapy that many illnesses are no longer so drastic nor prolonged that there is opportunity for full development of this factor of personal involvement of the physician. None of us would regard this as undesirable, for we are devoted by tradition and by our ideals to the furtherance of scientific knowledge and its skillful application in therapy. Rather, we continue to remind ourselves that if some erosion of these values is inevitable in the process of scientific advancement, that we must maintain this reduction to a minimum and we accept the compensating advantages of technologic progress with some degree of equanimity. So much, then, for the intrinsic merits of this personal factor and so much for the inevitable reduction in its value imposed by circumstances essentially out of our control even though they may spring from some of our own continuing endeavors.

There is a further danger to the survival of this essential human value which now

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Can hypnosis be used routinely in obstetrics?

T. D. Callan, M.D., Anaconda, Montana

A G.P. trained in hypnosis reports enthusiastically on the easy deliveries, lowered needs for pain medicine and anesthetics, and the fewer complications encountered when hypnosis is used in obstetrics.

SINCE 1957 I have delivered about 80 per cent of my maternity cases using hypnosis as a total or partial anesthesia. It is well known that most patients who are able to reach the deep stage of hypnosis, that is the somnambulistic state, will enjoy a painless labor and delivery and will remember little of what took place. However, only about 10 per cent of patients are able to reach this deep stage. It is the purpose of this paper to determine the benefit the patient receives who reaches the light or medium states.

The results are derived from a survey of maternity patients delivered by me in 1956, before using hypnosis as compared to a similar series of patients delivered in 1959 in whom hypnosis was used. No attempt was made to pick out the good subjects. All patients were asked after their initial physical examination if they wished to try hypnosis as an aid to their coming confinement and if they refused, no attempt was made to change their decision. Out of a total of 118 patients, 83 elected to use hypnosis as an aid to their delivery and 35 declined. These then were compared to a total of 86 patients delivered in 1956.

Initial induction

The initial induction of hypnosis was started about the fourth month of pregnancy or as soon as the patient presented herself if it was later than this time. The method of induction was fixed attention on the eyes of an object and, at the same time, strict concentration of the mind on one thought. There were no failures in induction but the depth of the trance or state varied considerably. No attempt at deepening procedures was made other than the direct suggestion that each time they entered the hypnotic state they would always go deeper.

The initial induction and suggestion treatment took a total time of about 25 minutes and each session following a total time of 10 minutes. The patients who were started at four months received a total of about 12 sessions. During each session of hypnosis, positive suggestions were made concerning her forthcoming delivery as to the lack of pain, nervousness, and tension. She was assured that she would have a fast and easy delivery. The patients were told that they would have complete control at delivery time, and that sedation and anesthesia would be available to them at any time requested. At the same session, positive suggestions were given concerning a feeling of well-being during the prenatal and postnatal course.

Benefits initially

The response of the common minor complaints of pregnancy to hypnotic suggestion is dramatic and this response occurs regardless of the depth of the hypnotic state reached. The patient who is able to reach only a light state of hypnosis receives the

same benefit as those who enter the deep states. In almost every case the patient noted a lack of tension, nervousness, and irritability. Insomnia was almost nonexistent, constipation eliminated, and heartburn, gas, nausea and vomiting removed entirely.

TABLE 1

	Summary of charts, 1956 Hypnosis not used		Summary of charts, 1959 Hypnosis used	
	Prima-para	Multi-para	Prima-para	Multi-para
Number of patients..	17	65	17	62
Total hours in labor..	191.5	545.5	127	204.5
Avg. hours in labor..	11.1	8.3	7.4	3.3
Episiotomy	16	27	17	28
Forceps	10	11	7	7
Ether anesthesia	10	11	0	0
Trilene anesthesia	17	65	16	52
1 per cent novocain anesthesia	16	27	17	28
No anesthesia	0	0	1	6
Sedation in labor				
a. 100 mg. Demerol	6	36	9	34
b. 200 mg. Demerol	11	3	6	3
c. No sedation	0	25	2	25

In comparing the charts there was considerable difficulty in determining the exact onset of labor. In order to make an equitable comparison, it was decided to count as the onset of labor the time that the patient was admitted to the hospital. Therefore all figures in the chart of Table 1 which relate to hours in labor mean from the time of admittance until delivery was accomplished.

There was a total of 83 patients who elected to use hypnosis as an aid to delivery. Four of these were repeat caesarian operations. They were conditioned for their pre- and postnatal course. The operation was done under general anesthesia. Of the remaining 79 patients, two of the primaparas and eight of the multiparas entered a light trance state. The medium state trance was obtained in 12 primaparas and 47 multiparas. The somnambulistic or deep state was attained by three primaparas and seven of the multiparas.

It was noted in Table 1 that the average duration of labor in the hypnosis group was markedly decreased over that of the control group. In the hypnotic group the primaparas averaged 7.4 hours of labor as compared to 11.1 hours for the control group. An average reduction of labor of 3.7 hours. In the hypnotic group multiparas averaged 3.3 hours of labor as compared to 8.3 hours for the control group, or an average reduction of labor of five hours.

The incidence of episiotomy was approximately the same in both groups. The incidence of forceps delivery in the hypnotic group was 41 per cent for the primaparas and 11 per cent for the multiparas as compared to the control's incidence of 58 per cent for primaparas and 16 per cent for multiparas. However, it was noted that in the control group deep ether anesthesia was needed to accomplish delivery in 10 primaparas and 11 multiparas. In the group using hypnosis, deep ether anesthesia was never used. All deliveries, including those in which forceps were used, were accomplished under Trilene inhalation with the Duke inhalator with no obvious discomfort to the mother and much obvious benefit to the child.

Local infiltration of the perineum with 1 per cent novocain was used in both groups where an episiotomy was done. In the control group there were no patients that did not require anesthesia. In the hypnotic group there were seven patients that required no anesthetic help of any kind. The sedation in labor of both groups was approximately the same excepting two primaparas in the hypnotic group who did not request or receive any sedation.

Labor and presentation

In the control group there were three frank breech presentations in multiparas having an average duration of labor of 4.1 hours as compared to two frank breech presentations and one double footling in multiparas in the hypnosis group who had an average duration of labor of one-half hour. In the control group there were two occiput posterior positions in multiparas with an average duration of labor of 18.5 hours as compared to three occiput posterior positions in multiparas in the hypnotic group with an average duration of labor of eight hours. In addition, in the hypnotic group there were three frank breech presentations and one

double footling in primaparas with an average duration of labor of 6.4 hours. There was no comparable group to this one in the control group.

In the hypnotic group there were no complications noted and no blood transfusions were needed. In the control group the following were noted: one postpartum infection, one postpartum depression, one case of uterine atony with one blood transfusion, one retained placenta with manual removal, and one deep transverse arrest which required caesarian section after 40 hours of labor.

There were four patients in each group that underwent ceasarian section for their delivery. Three of these patients were able to reach a medium state of hypnosis and the fourth never went deeper than a light state of hypnosis. In the control group of caesarian sections a total of 11 blood transfusions was given as compared to a total of six in the hypnotic group. All of the patients in the control group required sedation following delivery consisting of either M.S. gr ¼ or

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Preasthmatic patterns*

Frank T. Joyce, M.D., Denver

Asthma may be prevented. Important clinical clues, for those who are alert to them, precede the onset of full-blown asthma. Simple addition of irritant factors may determine whether the allergic person will have the clinical disease.

THIS IS A DISCUSSION OF A PREASTHMATIC PHASE of bronchial asthma. Asthmatic bronchitis, and, particularly, allergic bronchitis, is often a precursor to asthma. Persistent or paroxysmal coughing without wheezing is the most important symptom. The coughing may or may not be accompanied by nasal symptoms. When allergic nasal symptoms are present, the coughing is often attributed to the nasal pathology, such as a postnasal drainage. Or, if the coughing is considered to be due to bronchitis, the allergic nature of the cough may not be recognized.

Allergic bronchitis is seldom mentioned. In fact, among 13 texts on allergy, some of which pertain only to bronchial asthma, that have been published since 1947, allergic bronchitis is mentioned in only two books. One text[1] mentions allergic bronchitis as a clinical entity and the other[2] alludes to the allergic bronchitis in terms of latent asthma. Several of the older texts, prior to 1945, do describe allergic bronchitis and present illustrative cases. A description of the pathology of bronchial asthma contains all the features of allergic bronchitis and thus it is difficult, except by definition, to draw a line between the two.

Onset may be gradual

Paroxysmal wheezing and dyspnea are the diagnostic hallmarks of asthma but the diagnosis of asthma is often not considered until these findings are already present. It is as if one regarded asthma as developing in an all or none manner. It is reasonable to assume that in some patients bronchial asthma can develop in a more gradual way. It is well known that many patients who have nasal allergies will eventually develop bronchial asthma. This increase in the degree of hypersensitivity of the respiratory tract does not have to occur all at once. Some of these patients may be a long time in developing the typical asthma pattern.

*Read at the Midwinter Clinical Session, Colorado State Medical Society, Denver, February 18, 1960.

By using a classification of allergic bronchial disease which defines allergic bronchitis as an intermediate step toward the development of bronchial asthma we may be able to predict which patients have a much greater probability of acquiring bronchial asthma at a later date.

Asthmatic bronchitis

Coughing in allergic bronchitis is aggravated or precipitated by the same nonspecific irritants which aggravate bronchial asthma or other types of bronchitis. These are: exposures to cool or cold air, increased humidity and, especially, coughing during or following exertion. Coughing may occur with laughing, giggling, or crying. A respiratory infection which may occur during this phase aggravates the coughing and may, perhaps, cause wheezing which is then often called asthmatic bronchitis. Asthmatic bronchitis is bronchial asthma. Unusually frequent colds or prolonged coughing following colds are very typical signs. I think it is an important diagnostic point that the coughing does not respond too well to the usual type of therapy. The cough is helped most with the drugs which contain either the bronchodilators or the antihistamines, or both.

Allergic bronchitis occurs much more frequently than most people suspect. It is probable that many of the patients will not develop bronchial asthma. On the other hand, many patients with allergic bronchitis become increasingly more allergic and consequently acquire bronchial asthma.

Development of bronchial asthma

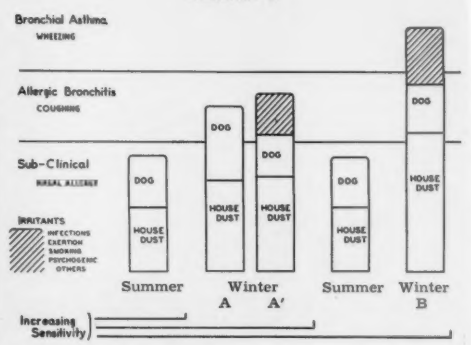
Chart 1 illustrates the pattern of increasing sensitivity of the respiratory tract. Asthma may begin abruptly but more often it requires one or more years for the asthma to become fully developed. The phases are graded: subclinical, allergic bronchitis, and bronchial asthma. In the subclinical phase the individual has no chest symptoms but he may have nasal symptoms of allergy and may have a family history of allergy. There may be a history of infantile eczema, usually frequent colds, "sinus trouble," repeated ear infections, or mouth breathing.

During the summer months the patient is usually free of symptoms. The mild degree of allergy and the lower exposure to the inhalants such as dust or dog do not exceed the threshold of the subclinical level. During the winter months, column "Winter A," the quantity of these inhalants is increased because the patient is inside the house more. The heating systems keep these inhalants moving about and the allergic components are significantly increased so that now the total exposure is above the subclinical level. The patient develops prolonged, paroxysmal attacks of coughing. In children the coughing may be severe enough at times to suggest whooping cough.

An alternate environmental situation is illustrated by the column "Winter A'." The coughing is particularly aggravated by irritants such as colds, infectious bronchitis, and exertion. Emotional upsets may bother him. During the summer months the exposure to the various inhalants and irritants has again been reduced and the patient may be quite comfortable. This cycle of events may persist over a period of several years. Wheezing rarely occurs and bronchial allergy may not be suspected. This represents the typical allergic bronchitis. If the environmental inhalants are decreased the patient may spontaneously improve in the winter months. This phase has been called "latent asthma."

As the patient becomes more allergic in the next several years, all of the allergic and irritative factors increase and the patient has advanced into the phase of bronchial asthma, Chart 1, column "Winter B." At first asthma occurs only with respiratory infections. This is commonly called "asthmatic bronchitis" but, nevertheless, it is bronchial

CHART 1



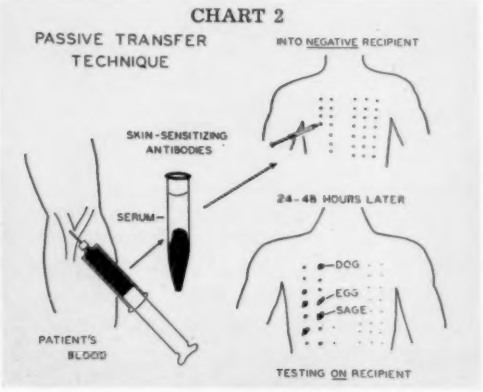
asthma. In the uncontrolled asthma patient infections of this sort almost always precipitate asthma regardless of the age of the patient.

Outgrowing asthma

Many patients may seem to have "outgrown" their asthma. Most of these patients, however, have not lost their allergies in any way. In most cases there has been an unintentional or accidental lowering of the quantity of one or more of the environmental inhalants. As an example, one might refer to Chart 1, column B. Assume that the dog dies or disappears and is not replaced. Gradually, the quantity of dog dander is eliminated from the home and the top of the column is lowered below the threshold for bronchial asthma. The patient's improvement is gradual and since the dog was never under suspicion in the first place, the family does not relate the favorable change to the elimination of the dog. Or, the family may have moved to another home within the same city which has a better heating system. There would be much less exposure to house dust and we would expect considerable improvement.

Allergic bronchitis patients who have too many colds or coughing which persists longer than normal may respond the same way. By eliminating or reducing either of these blocks the patient would have a better winter. Several years may elapse with the patient having almost no symptoms, but, finally, if they should acquire another dog or if he acquires some other type of allergy, he may start having symptoms of asthma again.

CHART 2



Allergy testing by passive transfer

This procedure is an excellent means of avoiding direct allergy testing on the patient and is particularly useful in children under 5 or 6 years of age. The technic is described in most texts on allergy. It is often referred to as the Prausnitz-Kustner phenomenon. In brief, the procedure is illustrated in Chart 2. The skin-sensitizing antibodies which are responsible for positive allergy tests are circulating antibodies. A blood specimen is allowed to clot and the sterile serum is then injected intradermally into a nonallergic adult recipient. Because allergies are so frequently hereditary it is often not possible to use one of the parents as the recipient. In most cases "professional" recipients are used.

A separate serum site is injected for each allergy test. The patient's antibodies attach themselves to the recipient's epidermal cells. Forty-eight hours later the passively sensitized sites are tested with separate antigens. The positive reactions develop in the same manner and degree as if they were done on the patient in the direct testing. The results of the skin testing offer valuable clues as to potential allergic offenders. Proper interpretation of the tests must emphasize that positive allergy tests alone are not proof, as such, that the patient is clinically allergic to the reacting test substance. The reacting tests shown in Chart 2 are hypothetical and do not illustrate the skin reactions described in the following case.

Two cases have been chosen to illustrate the principles which have been discussed.

CASE REPORTS

Asthmatic bronchitis. U. R., a boy, 19 months of age, was seen October 23, 1959, because of two severe episodes of pneumonia, the last attack being accompanied by unusually severe respiratory distress and wheezing. The baby had had frequent colds the previous winter and some respiratory difficulty in August, 1959, which was suspected to be allergic. He was hospitalized in September, 1959, for pneumonia. At that time laboratory studies for fibrocystic disease of the pancreas were negative. Allergy tests by the scratch method were done and were negative. He was readmitted October 20, 1959, for another attack of pneumonia with positive x-ray changes in the lungs.

Passive transfer allergy tests were done. There were a number of positive skin reactions but the

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Common sense in therapeutic irradiation*

R. R. Newell, M.D., San Francisco, California

Mature, sobering and philosophic insight into our present more or less chaotic perception of a therapeutic agent which has great potentialities for harm as well as good.

NO DOUBT THE INTENTION, when I was asked to discuss therapy by external irradiation, was to get some defense of Co-60 telecurie therapy and perhaps a play for Cs^{137}. I would, in fact, not like to practice without megavolt radiation, and would prefer one of those isotopes to even the most dependable of available accelerators. However, it is a dozen years since I have practiced the art. I am therefore choosing to spend time on some things that I believe to be as true and as pertinent now as they were when I last used x-rays, or when I began to use them 40 years ago.

In making a plea for common sense, I do not mean to abandon the scentific foundation —in fact, I like to think that science is only sophisticated common sense. What I am aiming at is to keep alert to the shortcomings of science and the occasional tubular vision that afflicts scientists. Also to watch out for the disturbing intrusions of sentiment!

The patient

Much is written about *rapport* between you (the physician) and your patient. You must understand the patient and his disease. He must have confidence that you do. *Rapport* is not spontaneous—it must be built. You and your patient do not see his "case" alike. Of course you don't! You see many cases like his, but for him it is a unique experience. You can quote (say) 50 per cent of five-year cures, but for him it is live or die, 100 per cent. The usual patient is unscientific but aware of the importance of science. Within limits you can hope to inform him about the pertinent pathology and proposed therapy. But you cannot expect to change his sentiments—you can only hope to learn about them. You may have to override, or better go around, strong prejudices. It is helpful if you can detect them before you collide with them. In brief: Your patient's ignorance is corrigible, his sentiments are not. You have to take his personality as you find it. You are fortunate if he has some common sense.

Sometimes we call on "common sense" when what we mean is courage and emotional stability. These are not given by logical argument. One can only hope to cultivate them in oneself and thus to induce them in the patient by emotional contagion. At the least, one can tactfully avoid breaking them down. Cold aloofness and sickly sentimentality can be equally destructive. Where the native endowment is small, or where the demands are large, the first few days are critical, while the patient is learning to understand his situation. In order to carry the

*Presented at Colorado State Medical Society Midwinter Clinical Session, February 28-March 3, 1961.

heavy load, his spiritual muscles must hypertrophy, and it takes time. I have been amazed many and many a time to see what discomfort, even misery, of radiation reaction my patient could endure, returning daily for additional exposure. The daily contact with the confident and sympathetic therapist had mobilized unexpected spiritual resources during the ten days or so before reaction. This contrasts with surgical treatment for which the patient may have to find the needed courage overnight.

The threat of radiation injury

Popular misconsceptions about radiation are probably inevitable. After all, people know radiation only at second hand, for it escapes the five senses. Naturally this lack of experience makes a vacuum well adapted to suck in false notions, which then readily expand into superstition and prejudice. Moreover, radiation, in the minds of all of us, is associated with nuclear warfare—an emotional subject, indeed!

Even a little radiation can produce genetic mutations. This has been well taught to everyone who will listen or read. This is readily confused with sterility (which can only be produced by large doses). And sterility is very generally confused with impotence. And so the (false) deductive chain is forged, uniting radiation with the liveliest of human sentiments, namely sex. There is your real opportunity to bring common sense into the troubled mind.

Examples abound of illogical fear of diagnostic exposures. Notably, genetic injury is not clearly distinguished from somatic injury to the person exposed. Moreover, emotion is commonly lavished on those exposures which carry the smallest hazard, namely, dental films and routine chest films.

The therapist, however, is rarely impeded by his patient's fear of radiation, since, in this case, the destructive effect of radiation on living tissue is the very reason for its being used. Moreover, they actively dislike the alternative—the knife. Given this situation, preadapted for common-sense acceptance of the inescapable unpleasantness, the therapist would be foolish to let his explanations rise above a matter-of-fact level. On the other hand, he would be downright shortsighted to pooh-pooh the dangers and discomforts.

The therapist

Common sense and intuition are built on personal experience. They can serve some bright minds very well without benefit of schools of logic. No doubt common sense is broadened by the gradual spread of science into our culture, where it becomes part of the upbringing of the child by its parents and contemporaries. Science is conscious and communicable. It draws on the experience and observations and logical operations of many men, past and present. I'm sure every therapist tries hard to make the scientific foundation effective for his therapeutic art. My thesis is that he needs common sense as well, including that special common-sense ingredient of clinical judgment that comes from clinical experience.

Some of this sinks below the level of conscious logic and emerges as intuition. Some of it is ostensibly logical but of untested validity. A personal experience of half a dozen cases looms very large in a therapist's mind—perhaps as weighty as what he has read about a hundred cases in other people's hands. The index of illogic should not be read as 16:1, however, because he really does know much more about his six personal cases than could ever be written into a report. It is quite proper that the application of science should be influenced by personal clinical experience. It is up to common sense to keep the good horse from shying at some novelty, taking the bit in its teeth and running away with the entire management. It is, in fact, the unusual case that most needs some common sense.

The unusual case

It is hard for a person not to overact when he finds that his patient presents a rare disease or an unusual problem. The high motivation has sweet uses, however. The intense library work can accomplish as much postgraduate education as could be purchased for $150 plus three days' travel. The therapist's rare cases are mostly cancers and with a bad

prognosis. Their very rarity makes the published statistics unreliable and unhelpful. Common sense ought to tell the therapist that it will be impossible ever to know for sure whether his therapeutic decisions were really good or bad—however well or ill the case turns out.

Overoptimism

Radiation therapy has always been overevaluated. The therapist's wish to succeed and the patient's wish to get well push hard toward optimism. For the latter this force is extreme when he feels himself in the shadow of death. The wish to believe works both long and hard when the disease is chronic and the therapy protracted—as in cancer. For any therapy, optimism is a good adjuvant, but as a guide it needs tempering with common sense. When one sees things brighter than they are, one can miss the somber path that might otherwise be seen as the best choice.

Theory and empiricism

We all spent many years laying in the scientific foundation that a physician needs, and the special science that a radiologist needs. Science today is in high fashion. But our medical theories stand continually in need of validation—empirical testing. Empiricism alone, called trial and error, runs a discouraging frequency of error. Yet empiricism does have its triumphs, as witness quinine for malaria, cocaine for fatigue and the poppy for pain. But when medicine became highly theoretical, as in the past it has always tended to, some pretty impotent practices have resulted, as witness acupuncture and homeopathy—and some pretty damnable ones, too, as witness phlebotomy and the moxa. It is only common sense to insist that one's therapeutic theories be validated.

Therapeutic trials and statistics

So we have therapeutic trials. There is a technic to extract the most information from the observed results. Its name is statistics and most of us are not too handy with it. It is fashionable to question conclusions so arrived at, and even to impugn the integrity of those who use it. Yet statistics is founded on the same conviction that all science stands on, namely that this is all one world and you can expect to find the same uniformities tomorrow that you observed today. Only statistics treats nonuniformity as one of the measurable uniformities.

Only those therapists (or teams) that see very many patients with a particular disease can collect enough of a kind to yield conclusions worthy of some confidence. Such therapists owe it to humanity to hold fast to one therapeutic policy and technic long enough to collect significant statistics. It is fashionable to exhort the young physician to treat the patient, not the disease. And so indeed he should remind himself that his goal is life, not death—to save the patient, not blindly to kill the disease. But when the disease is one for which therapy is on shaky foundation, then one has but little faith that the standard treatment is actually inferior to a special treatment individually designed. The result is that no two are treated alike. Very likely all one has accomplished by "individualization" is to make certain that those who do well will have nothing in common to ascribe it to. Let us not call the man pig-headed who adheres to a uniform therapeutic policy through thick and thin. He may be doing as well as anyone could do for his patients today, while holding fast to the chance that his observations will give something very valuable to such patients in the future.

Cancer cases

Cancer has long dominated the therapist's practice. It will likely fill his horizon more and more as medical discoveries make it less and less likely that patients can die of anything except cancer or coronary disease. But cancers don't come to us in classes; they come singly. Moreover, the next case is different, and so for the less usual kinds, a given therapist's experience is represented by a "series of one." In many a case, then, the therapy must be managed on general principles (i.e., theory), or by what some other therapist has seen and reported—usually to support a theory. Even those whom you put in the same category (diagnosis) and same stage are not all the same. A particular patient may present a type of cancer common in your own

experience, with a well standardized treatment commonly deemed advisable. Or it may be one on which "authorities differ."

Still one cannot withhold treatment from the present patient just because medical science has not yet made the matter sure. One has to do the best one can "in the present state of the art." Against cancer this often means to use radiation not because one knows for sure that it is very good, but because one knows of nothing that is better.

Science and clinical investigation

With this picture before us—a very chronic lethal disease, of which our knowledge is inadequate, we have a duty to look hard at each case and keep good records of what we see and do. We can only find the uniformities to weave into science if we keep on hunting for them.

Teaching and training

Year by year we send our residents out to face the difficulty of gathering pertinent clinical experience of a pleomorphic disease. We have taught them the best we know and given them the teachings of others. We should also see that they get their eyes and hands on as many different cancer cases as we can. We can't show them more than a fraction of what we could wish them to know first hand. The broadening of their experience comes year by year as they see more and more patients. And their scientific foundation broadens and deepens as they puzzle about these patients and "read up" about their diseases—what the older hands have written and what's newly written in the journals. The rate of maturation of the therapist depends on this—the number of new cases he sees and studies. External irradiation for cancer is usually in divided doses. If the average series is 20 doses and takes a month, then the number of new cases per month is limited to the number treated per day. The radiologist who can give only part time to therapy is seen to be running under an educational handicap.

Oscillations of expectation

It is interesting to follow the rise and fall of popular and professional hope for the control of cancer. I have myself lived through many oscillations. Every report of a new advance in quality of radiation or novel method of production or application is followed by an accession of hope. Often the new irradiation is used in larger tissue dose than was being dared previously. This has generally been rewarded by greater effect on the neoplasm. Only after some months or years, the disastrous late ulcerations and fibroses appear in sufficient frequency to compel a revision of dosage policy. The response of the tumors is then not so great, and it is found that the betterment ascribed to the new therapy has to be reassessed. Hope dissolves away and the general attitude toward the cancer problem sinks toward the earlier despondent level—until a new improvement in hardware sets off a new wave of hope. Common sense is supposed to be a corrective for unfounded expectations.

I remain an unrepentant partisan of Common Sense even though Common Sense assured me of the impossibility of a nuclear bomb. Common Sense has been telling me for 40 years that radiation is not the solution to the cancer problem and never will be. I hope that I may keep my credulity tempered by Common Sense until at last the effective solution does in fact appear. I shan't cry if that time, too, I'm found a day late in my acceptance. What's a day lost out of a year of jubilation?

Apparatus

Therapists in many places are exploring the clinical usefulness of Co^{60} gamma rays and the bremsstrahlung from very powerful accelerators, i.e., resonance transformers and van de Graaff machines at a megavolt or two, linacs at six or eight megavolts, betatrons at six to 30 megavolts and a synchrotron at 70 megavolts. All are expensive. The therapist must have a strong conviction of the clinical value of such equipment to warrant the large investment. They provide excellent opportunity for the exhibition of intellectual honesty and a devotion to objective analysis. One might say that the invested Au-197 radiates influence as Au-198 radiates gamma rays. The sympathetic understanding and (virtual)

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Colorado Medical Student Awarded summer scholarship

Mr. K. Mason Howard, Jr., of 4525 East Yale Avenue, Denver 22, Colorado, who is in his third year at the University of Colorado Medical Center, Denver, Colorado, has been awarded a $600 scholarship for research and clinical training in the field of the allergic diseases by the Allergy Foundation of America. Mr. Howard will carry out his research work under the direction of Dr. David W. Talmage, Professor of Medicine and Microbiology at the University of Colorado, Denver, Colorado.

Mr. Howard was born in Denver, Colorado, and is married. He served four years in the U. S. Navy. Mr. Howard received his B.A. degree in 1958 in Zoology at the University of Denver. He is a member of the Waring Society, a local honorary seminar group.

Mr. Howard's research will be largely concerned with studies of antibody producing cells in inbred experimental animals.

Symposium on medical and surgical advances

The Southeastern Chapter of the Colorado Academy of General Practice, with the cooperation of Lederle Laboratories, are having a one-day symposium to be held in Pueblo, Colorado, Sunday, September 10, 1961, at the Pueblo Continental Motor Hotel.

Registration at 8:30 a.m. Luncheon and cocktail hour. Style show for the wives.

The symposium will be on Medical and Surgical Advances. The program includes the following subjects:

1. "Circulatory Disorders," George L. Jordan, M.D., Baylor University, Texas Medical Center, Houston, Texas.

2. "Myocardial Infarction," Gilbert Marquart, M.D., Associate Professor of Medicine, Northwestern University School of Medicine, Chicago, Illinois.

3. "Recent Advances in Surgery of Infants and Children," Tague C. Chisholm, M.D., Department of Surgery, Minnesota School of Medicine, Minneapolis, Minnesota.

4. "Today's Answers to Gynecologic Problems in Adolescents and Adults," Goodrich Schauffler, M.D., Portland, Oregon.

Reservations for this symposium may be made with Samuel Nelson, M.D., 212 Colorado Building, President of the Southeastern Chapter of the Colorado Academy of General Practice, by September 1, 1961. Reservations for the wives will be handled by Mrs. Samuel Nelson, 205 Argyle, Pueblo, Colorado.

Annual Session announcement

The Annual Session of the Colorado State Medical Society will be combined this year with the Congress on Occupational Health, sponsored by the American Medical Association. The meeting will be held at the Brown Palace and Shirley Savoy Hotels in Denver on October 1 to 4.

The morning program for October 2, Monday, will feature veterinary medicine, with the following speakers: Colonel Fred Mauer, Army Medical Research Laboratories, Fort Knox; Dr. David Detweiler, University of Pennsylvania; Dr. Charles Durbin, Director, Veterinary Division of the Food and Drug Administration; and General J. A. McCallam, of the Washington office of the American Veterinary Medical Association. Dr. Mark Morris, Fort Collins, Colorado, President of the American Veterinary Medical Association, will also participate.

The afternoon program for October 2 will feature talks of interest to general practitioners and will include the following speakers: Dr. Murray S. Hoffman, Dr. Albert P. Ley, Drs. Gordon Meiklejohn and Reginald Fitz, Dr. Charley J. Smyth, Drs. Charles G. Freed and Harry R. Boyd, Dr. Foster Matchett, all of Denver; and Dr. V. V. Anderson, President-elect, Colorado State Medical Society, Del Norte.

The October 3 and 4 programs have been scheduled for the Congress on Occupational Health and will include the following participants: Dr. Donald J. Birmingham, Cincinnati; Dr. W. Daggett Norwood, Richland, Washington; Dr. Elston L. Belknap, Marquette University School of Medicine; Dr. Robert R. Yanover, Albertson, New York; Dr. R. Lomax Wells, Washington, D. C.; Dr. Harry E. Tebrock, New York City; Dr. Leonard E. Himler, Ann Arbor, Michigan; Dr. Cecil Wittson, University of Nebraska; Miss Sara P. Wagner, New York City; Dr. Roger S. Mitchell, University of Colorado Medical School; Dr. Frank J. Princi, University of Cincinnati; Dr. Giles F. Filley, University of Colorado Medical School; Dr. Arthur J. Vorwald, Wayne University College of Medicine; Dr. Robert F. Bell, University of Colorado Medical School; Dr. Melvin N. Newquist, Clearwater, Florida; Mr. Theodore C. Waters, Baltimore; Dr. Samuel P. Newman, Denver; Mr. Jack E. Linster, Wausau, Wisconsin; Mr. Harold C. Thompson, Colorado State Compensation Insurance Fund; Dr. James G. Gaume, Denver.

Further information may be obtained by writing to the Colorado State Medical Society, 835 Republic Building, Denver 2, Colorado.

Obituaries

Outstanding contributor to public health on national level dies

Dr. Walter L. Bierring, who was the oldest living Past President of the American Medical Association and one of the most beloved physicians in American medical circles, died on June 24, 1961, in Des Moines, Iowa.

Walter Bierring was born July 15, 1868, and had a long and wonderful record in Iowa medical circles and then with the American Medical Association. He was known as the "dean" of Iowa medical practitioners, and served his state in four distinct areas. Noted first as an excellent private practitioner, he then became an outstanding medical educator. Then he was the State Commissioner of Public Health and finally the Director of Gerontology for the Iowa Health Commission.

Dr. Bierring first served the A.M.A. as Chairman of the Section on Pathology and Physiology in 1907. In 1919 he was elected Chairman of the Section of Medicine and in 1934 he became President of the A.M.A. He received the coveted Distinguished Service Award in 1956. His greatest work was in his liaison between the public health physician and the physician in private practice.

He was licensed in 1894 in Colorado and was an honorary member of the Colorado State Medical Society

Truly, as Dr. Askey so nicely wrote, "Medicine and the nation have lost a most dedicated and remarkable physician and citizen. All physicians everywhere are saddened by his death and everyone extends his deepest sympathy to his family."

Denver loses former chief of staff

Dr. Charles E. Pate of Denver, a practicing physician and surgeon for 56 years, died recently at his home. Charles E. Pate was born on April 21, 1880, in Saline County, Missouri, and came to Colorado in 1889. He attended Boulder public schools, the University of Colorado, and was graduated in 1905 from the Denver and Gross College of Medicine. While at Boulder, he was an outstanding athlete during his college years, captain of CU's basketball team and also participated in baseball and football. He was an honorary member of the C. Club.

He became a member of the Denver County Medical Society in 1905 and had practiced in Denver since then.

Dr. Pate was associated with the Denver Health Department from 1918 until 1923, served as chief of staff at Presbyterian Hospital and was a member of the International College of Surgeons.

In addition to being a member of the Denver Medical Society, Dr. Pate was a member of the Colorado State Medical Society and the American Medical Association, the Sigma Alpha Epsilon Fraternity and the Denver Athletic Club.

Surviving are three daughters and a son.

Regional Conference on Medical Education

"Medical Education and Health Sciences in the West," will be the subject of a special one-day conference at the University of Utah, Salt Lake City, on September 12, 1961. The conference will be jointly sponsored by the Western Interstate Commission for Higher Education (WICHE) and "What goes on."

The Presidents of the 13 state medical societies in the WICHE region are being especially invited by WICHE to attend this meeting. Other society officers, Executive Secretaries and Counselors from the six-state Rocky Mountain Medical Conference region will receive special notices of the meeting with invitations to attend.

The program will consist of panel presentations and discussions of the following: (a) educational needs in medicine and the health sciences and what is currently being done regionally by WICHE to meet these needs; (b) initial experiences of state medical societies with recruitment programs; (c) planning, building and expanding medical schools—problems and pitfalls.

Nationally recognized experts in health manpower and medical education will participate as speakers and panelists.

The conference is financed by WICHE through its grants from the Commonwealth Fund to strengthen the regional approach to medical education in the West. The Program Planning Committee includes the following: Alfred M. Popma, M.D., Boise, Idaho, WICHE Commissioner and current Chairman of the Commission; Lloyd M. Evans, M.D., Laramie, Wyoming, WICHE Commissioner; John C. Waldo, M.D., Salt Lake City, Program Chairman, Utah State Medical Society Meeting, and Secretary of the Society; Myron C. Waddell, M.D., Denver, Chairman, Committee on Medical Education and Hospitals, Colorado State Medical Society, and editor of "What goes on."

All physicians attending the 1961 Utah State Medical Society meeting are invited to attend the WICHE-"What goes on" Regional Conference on Medical Education. Those planning to attend are asked to fill out and mail in the registration form below.

To: Dr. Kevin Bunnell, Associate Director,
Western Interstate Commission for Higher Education,
Fleming Law Building,
Boulder, Colorado.

I wish to register for the Regional Conference on Medical Education to be held at the Little Theater, University of Utah Union Building, Salt Lake City, on September 12, 1961. Please send me the final printed program as soon as it is ready.

(Date)..... Signed.....
Name

.....
Address

Eighty-third Annual Meeting

Montana Medical Association

September 14, 15, 16, 1961—Great Falls—Hotel Rainbow

All physicians in the Rocky Mountain area are cordially invited to attend the 83rd Annual Meeting of the Montana Medical Association in Great Falls on Thursday, Friday, and Saturday, September 14, 15 and 16.

On Wednesday evening, September 13, a large number of medical specialty groups plan to meet. Among the groups which have already scheduled meetings on Wednesday evening are: Montana Society of Internal Medicine; Montana Pediatrics Society; Montana Society of Psychiatry, Neurology, and Neurosurgery; Montana Radiological Society; Montana Academy of Oto-Ophthalmology (an all-day session will be held at the Cascade County Convalescent Hospital); and the Montana Urological Society.

Thursday morning, September 14

10:10—"The Problems of the Pleural Space," G. Hugh Lawrence, M.D., Seattle, Washington

10:50—"Fluid and Electrolyte Replacement in Ileus Peritonitis and Chronic Shock," Hugh R. K. Barker, M.D., New York, New York

11:40—"Peptic Ulcers in Children," H. Milton Berg, M.D., Bismarck, North Dakota

12:10—Luncheon recess

Thursday afternoon, September 14

2:00—"Photocoagulation in the Treatment of Eye Diseases," Dohrmann K. Pischel, M.D., San Francisco, California

2:40—"Trends in Professional Liability," Alex Blewett, Jr., Attorney at Law, Great Falls

3:40—Recess

4:00—Round table conference: "Custodial Institutions of Montana," Earl L. Hall, M.D., Chairman, Great Falls (Other participants to be announced)

Friday morning, September 15

9:00—"Safety Through Seat Belts" (Motion picture presented by the Committee on Highway Safety of the Montana Medical Association, under the chairmanship of W. J. McDonald, M.D., Missoula)

9:20—"Studies on Renal Diseases in Childhood," Robert A. Good, M.D., Minneapolis, Minnesota

10:00—"Decisions in the Management of Acute and Chronic Cholecystitis," G. Hugh Lawrence, M.D., Seattle, Washington

10:40—Recess

11:00—Symposium: "Exfoliative Cytology," Robert E. Asmussen, M.D., Great Falls, Chairman (Other participants to be announced)

12:00—Luncheon recess

Friday afternoon, September 15

2:00—"Unrecognized Foreign Bodies in the Food and Air Passages," Paul G. Bunker, M.D., Aberdeen, South Dakota

2:40—"Current Concepts of Edema and Its Management," John P. Merrill, M.D., Boston, Massachusetts

3:20—Recess

Saturday morning, September 16

9:00—"Rheumatoid Arthritis in Children," Robert A. Good, M.D., Minneapolis, Minnesota

9:40—"Current Problems in the Management of Hypertension," John P. Merrill, M.D., Boston, Massachusetts

10:20—Recess

10:40—"Radical Pelvic Surgery in the Treatment of Female Pelvic Malignancy," Hugh R. K. Barber, M.D., New York, New York

11:00—Round table conference: "Limitations of Office Practice" (Chairman and participants to be announced)

The House of Delegates of the Association will convene for its opening session at 8:30 o'clock, Thursday morning, September 14. The second session of the House of Delegates will convene at 3:45 o'clock on Friday afternoon, September 15; the final session, at 1:30 o'clock on Saturday afternoon, September 16. The House of Delegates will recess the Saturday afternoon sesssion to convene as the administrative body of Montana Physicians' Service. Upon the adjournment of the administrative body, the House will reconvene for the election of officers and for their installation.

On Thursday evening, September 14, the Montana Medical Association will sponsor its annual reception and banquet at the Rainbow Hotel. The evening program will include an address by a speaker of prominence, and entertainment.

Harold W. Fuller, M.D., Great Falls, is acting President of the Montana Medical Association in the absence of Raymond F. Peterson, M.D., who was elected to this office last September but who moved to California. The other officers of the Association are: Everett H. Lindstrom, M.D., Helena, President-elect; W. E. Harris, M.D., Livingston, Secretary-Treasurer; and Albert L. Vadheim, Jr., M.D., Assistant Secretary-Treasurer. Ernest J. Eichwald, M.D., Great Falls, is Chairman of the Program Committee and Eugene J. P. Drouillard, M.D., Missoula, Vice Chairman. The other members of this committee are: Hugh V. Anderson, M.D., Great Falls; Robert E. Asmussen, M.D., Great Falls; William J. McDonald, M.D., Missoula; Donald C. Overy, M.D., Great Falls; and Wyman J. Roberts, M.D., Great Falls.

Fifty-eighth Annual Meeting

Nevada State Medical Association

Jointly with

Eleventh Annual Conference

Reno Surgical Society

August 23-26, 1961—Reno, Nevada—The Mapes Hotel

E. Vincent Askey, M.D.
Immediate Past President
American Medical Association

Howard E. Bradshaw, M.D.
Professor and Head
Department of Surgery
Bowman Gray School of Medicine
Wake Forest College
Winston-Salem, North Carolina

John W. Cline, M.D.
President, American Cancer Society
and
Associate Clinical Professor
of Surgery
Stanford University
San Francisco

GUEST SPEAKERS

Tuesday, August 22, 1961

8:00 p.m.—Executive Committee Meeting, Nevada State Medical Association

Wednesday, August 23, 1961

Registration: The Mapes Hotel. Fee: $20.00

Morning

9:00-12:00—Nevada State Medical Association Orientation Course for new members

Afternoon

2:00—Nevada State Medical Association House of Delegates

Thursday, August 24, 1961

Morning

9:00—Official Greetings: Leo D. Nannini, M.D., President, Reno Surgical Society
Moderator: O. E. Grua, M.D., President, Ogden Surgical Society
9:10—Dr. Muelling, "The Treatment of Poisoning"
9:50—Coffee Break and Exhibits
10:20—Dr. Bradshaw, "Hyperparathyroidism"
11:05—Dr. Kerr, "Late Complications in Diabetes Mellitus"
11:45—Exhibits
12:00—Luncheon for Doctors and their Ladies—Skyroom of the Mapes Hotel. Speaker: Honorable Grant Sawyer, Governor of the State of Nevada

Afternoon

Moderator: Robert E. Staley, M.D., President, Idaho State Medical Association
2:00—Dr. Lillehei, "Treatment of Chronic Complete Heart Block with Adams Stokes Syndrome by Pacemaker Implantation"
2:45—Dr. Collins, "Embolism in Obstetrics"
3:25—Coffee Break and Exhibits
3:55—Dr. Cline, "Surgical Aspects of the Common Bile Duct"

Evening

7:00—Barbecue, Dance, Hidden Valley Country Club

Friday, August 25, 1961
Morning
Moderator: Max H. Parrott, M.D., President, Oregon State Medical Society, Portland
9:00—Dr. Askey, "Adrenal Gland Tumors"
9:40—Coffee Break and Exhibits
10:20—Dr. Collins, "The Urinary Tract and Pelvic Surgery"
11:00—Dr. Muelling, "The Contribution of Toxicology to the Science of Proof"
12:00—Panel Luncheon, Riviera Room, Riverside Hotel
Moderator: Gilbert G. Lenz, M.D.

Afternoon
Moderator: Warren L. Bostick, M.D., President, California Medical Association
2:00—Dr. Kerr, "Some Problems with Staphylococcus Infections"
2:45—Dr. Bradshaw, "Portal Hypertension"
3:25—Coffee Break and Exhibits
3:55—Dr. Lillehei, "Acquired Heart Lesions Amenable to Surgical Correction by Open Heart Methods"

Evening
Banquet—Garden Room, Riverside Hotel

Saturday, August 26, 1961
Morning
9:30—Round Table Discussion. Moderator: Dr. Cline. Panel will be composed of guest speakers. Questions will be submitted in writing
11:00—House of Delegates Meeting, Nevada State Medical Association

Woman's Auxiliary Program

Wednesday, August 23, 1961
Registration—The Mapes Hotel

Thursday, August 24, 1961
Morning
10:00—Business Meeting
12:00—Luncheon with Doctors—Skyroom of the Mapes Hotel

Afternoon
2:00—Formal opening of the Annual Meeting, Nevada Room, Mapes Hotel. Message from President Wesley W. Hall, M.D., Nevada State Medical Association

Evening
7:00—Barbecue, Dance, Hidden Valley Country Club

Friday, August 25, 1961
12:00—Luncheon at The Lancer honoring Mrs. Harlan English, President, Woman's Auxiliary to the American Medical Association

Afternoon
2:00—General Business Session—Eugene's

Evening
Cocktails and Banquet—Garden Room, Riverside Hotel

GUEST SPEAKERS

Conrad G. Collins, M.D.
Professor and Head
Department of Obstetrics
and Gynecology
Tulane University School of Medicine
New Orleans, Louisiana

Robert B. Kerr, M.D.
Professor and Head
Department of Medicine
University of British Columbia
Vancouver, Canada

C. Walton Lillehei, M.D.
Professor of Surgery
Medical School
University of Minnesota
Minneapolis

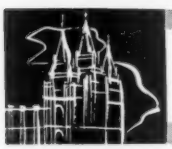
Rudolph J. Muelling, Jr., M.D.
Professor of Pathology and Head
of the Division of Legal Medicine
and Toxicology
School of Medicine
University of Kentucky
Lexington

NEW MEXICO

Roswell doctor honored

George S. Richardson, M.D., Roswell, N. M., and late of Albuquerque, N. M., was elected to active Fellowship in the American Laryngological, Rhinological and Otological Society. This honor implies an obligation of regular attendance at meetings, presentation and discussion of papers and reporting on research and clinical problems relating to this specialty.

Dr. Richardson is the first Otolaryngologist in the State of New Mexico to have been elected to the "American Triological Society."



UTAH

Allergy Foundation names Utah Medical student for summer scholarship award

Mr. Chesley R. Davies of Salt Lake City, student at the University of Utah College of Medicine, has been awarded a $600 scholarship for research and clinical training in the field of the allergic diseases by the Allergy Foundation of America. Mr. Davies will carry out his research work under the direction of Dr. Stanley Marcus, Professor of Bacteriology and Immunology.

Mr. Davies' research will be largely concerned with Passive Cutaneous Anaphylaxis (PCA) studies in the mouse.

WYOMING

Community service award

Plans to present an annual award to a Wyoming physician for outstanding community service have been unveiled by Francis A. Barrett, M.D., President of the Wyoming State Medical Society. The award will be presented in cooperation with the A. H. Robins Company, national pharmaceutical firm.

Nomination forms have been sent to county medical society presidents, county and district school superintendents, secretaries of Chambers of Commerce, and newspaper publishers throughout the state, together with a covering letter asking their assistance in determining the recipient of the award.

"We know that many Wyoming doctors take an active role in community affairs," Barrett stated. "Many of our physicians are especially active in youth programs and school affairs. Many others take an active part in the work of community clubs and other civic organizations. In presenting this award, the State Medical Society hopes to extend a measure of recognition to a person who is not only a worthy member of the medical profession, but an outstanding member of his community."

Presentation of the award will be made in September at the group's annual convention.

National Fund for Medical Education

Contributions from industry to the National Fund for Medical Education in 1960 reached a new high of $2,418,221, S. Sloan Colt, President of the National Fund, recently announced.

These figures were contained in the 1960 Annual Report of the Fund, and this sum represents an increase of 8.8 per cent over money contributed in 1959. Aided by a matching grant of $919,000 from The Ford Foundation, the Fund was enabled to make awards to the nation's 85 medical schools of $3,138,460. This is an increase of $100,000 over grants made in 1959.

Over 1,900 corporations contributed to the Fund in gifts ranging from $100,000 to $5.00. In addition, some $23,219 was received from individuals for the Fund's Teaching Budget Program.

Urology award

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to urologists who have been graduated not more than ten years, and to hospital interns and residents doing clinical or laboratory research work in Urology. Animal research is not necessary.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Bellevue-Stratford Hotel, Philadelphia, Pennsylvania, May 14-17, 1962.

For full particulars, write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore 1, Maryland. Essays must be in his hands before November 15, 1961.

Francis A. Barrett, M.D.
President, Wyoming State
Medical Society

Fifty-eighth Annual Meeting

Wyoming State Medical Society

September 18-22, 1961—Moran—Jackson Lake Lodge

For Reservation Information, contact Grand Teton Lodge Co., Reservation Dept., Jackson, Wyo.

Monday, September 18, 1961

3:00—Registration, Jackson Lake Lodge

3:00—Meeting, Advisory Committee to Wyoming State Hospital, Jackson Lake Lodge

6:00—Cocktails, Sun Deck

7:00—Exhibitors Buffet and Medical Entertainment, Arthur Abbey, Executive Secretary, Wyoming State Medical Society, Presiding. Stag Night to follow buffet

Tuesday, September 19, 1961

BUSINESS

7:30—Council Breakfast

9:00—House of Delegates

10:00—Recess to View Exhibits

10:30—House of Delegates

11:45—Nominating Committee

12:15—Luncheon—"Meet the Speakers," John Froyd, M.D., Secretary, Wyoming State Medical Society, Presiding

SCIENTIFIC SESSION

Wallace Brooke, M.D., President, Utah State Medical Association, Presiding

2:00—"The Treatment of Diabetic Coma and Acidosis," L. A. Smith, M.D.

2:30—"The Care of the Pregnant Diabetic," E. A. Banner, M.D.

3:00—Recess to View Exhibits

PROBLEMS TO THE PANEL:

Ten minute case reports by Wyoming doctors followed by panel discussion, questions and answers. Mayo team: Drs. Smith, Banner, Ferris, Soule

3:30—Case: "Acute Pancreatitis," Howard Greaves, M.D.

3:40—Panel

4:00—Case: "Vaginal Bleeding and Anemia," George Johnson, M.D.

4:10—Panel

4:30—Case: "Uremia of Pregnancy," Joseph Hellewell, M.D.

4:40—Panel

Wednesday, September 20, 1961

7:30-8:30—Fellowship Breakfast

SCIENTIFIC SESSION

Cyrus W. Anderson, M.D., President, Colorado State Medical Society, Presiding

9:00—"The Diagnosis and Management of Congenital Hips," A. J. Bianco, M.D.

9:30—"Is It Glands, Doctor?" A. B. Hayles, M.D.

10:00—Recess to View Exhibtis

WYOMING CASE REPORTS AND CRITIQUE

By Mayo Team: Doctors Bianco, Hayles, Ferris, Soule

10:30—Case: "Long Bone Fractures," H. B. Anderson, M.D.

10:40—Panel

11:00—Case: "Acute Appendicitis," John Froyd, M.D.

11:10—Panel

11:30—Case: "Non-Descent Testicle," S. J. Giovale, M.D.

11:40-12:00 noon—Panel

12:15—Luncheon: Presentation of Robins Award for Community Service. Benjamin Gitlitz, M.D., Immediate Past President, Wyoming State Medical Society, Presiding

BUSINESS

2:00-4:00 — Resolutiions (Reference) Committee Meeting, West Conference Room off Explorers Room

"THREE RING CIRCUS"

2:00-4:00—Ring No. 1—West Conference Room off Explorers Room. Round-table discussion in Surgery, Pathology, Internal Medicine, Pediatrics, Ob-Gyn.

Ring No. 2—Meeting Room, Practical Orthopedic Clinic with Dr. Bianco and Wyoming Orthopods. Team A—Drs. Kline and Preston; Team B—Drs. Anderson and Cashman

Ring No. 3—Explorers Room. Medical movies from the Mayo Clinic

Thursday, September 21, 1961

7:30-8:30—Fellowship Breakfast

SCIENTIFIC SESSION

E. H. Lindstrom, M.D., President, Montana State Medical Society, Presiding

9:00—"Gallbladder Disease, Diagnosis and Treatment," D. O. Ferris, M.D.

9:30—"Problems of the Cytologic and Tissue Diagnosis of Cancer," E. H. Soule, M.D.

10:00—Recess to View Exhibits

WYOMING CASE REPORTS AND PANEL OPINION

By Mayo team: Drs. Ferris, Soule, Smith, Hayles, Banner

10:30—Case: "Intestinal Obstruction," Virgil L. Thorpe, M.D.

10:40—Panel

11:00—Case: "Papillary Carcinoma Thyroid," Henry Tsumagari, M.D.

11:10—Panel

11:30—Case: "'Peripheral Vascular Embolus," Ray Christensen, M.D.

11:40-12:00 noon—Panel

12:15—Luncheon: B. J. Sullivan, M.D., Delegate to A.M.A., Presiding. Speaker: Dr. Robert Kroepsch, Director, WICHE, "Medical Education in the West"

BUSINESS

2:00-4:00—House of Delegates

2:00-4:00—Movies from Mayo Clinic

4:00-4:30—Council Meeting

Friday, September 22, 1961

7:00-8:15—Fellowship Breakfast

SCIENTIFIC SESSION

Francis A. Barrett, M.D., President, Wyoming State Medical Society, Presiding

"Recent Advances"

8:30—Surgery, D. O. Ferris, M.D.

8:50—Orthopedics, A. J. Bianco, M.D.

9:10—Medicine, L. A. Smith, M.D.

9:30—Recess to View Exhibits

10:00—Obstetrics and Gynecology, E. A. Banner, M.D.

10:20—Pathology, E. H. Soule, M.D.

10:40—Pediatrics, A. B. Hayles, M.D.

11:00-12:00 noon—Critique, Panel Discussion, questions and answers

12:15—Luncheon: "The A.M.A. and Current Legislation," C. D. Anton, M.D., Treasurer, Wyoming State Medical Society, Presiding. Speaker: C. Joseph Stetler, Director, Legal Division, American Medical Association

2:00—*MEDICAL-LEGAL SEMINAR*

Moderator: C. Joseph Stetler, Director, Legal Division, A.M.A.

3:30—Orientation Program

4:30—Adjournment

Our Guest Speakers from the Mayo Clinic

Dr. Edward A. Banner

Dr. A. J. Bianco

Dr. D. O. Ferris

Dr. A. N. Hayles

Dr. Lucian Smith

Dr. E. H. Soule

A fine program has been prepared by the Woman's Auxiliary to Wyoming State Medical Society.

Auxiliary meetings will be held in the West Conference Rooms just off the Explorers Room.

casts its heavy shadow across all the future. This is, of course, the threat of political domination *over* and bureaucratic control *of* the practice of medicine.

Federal incursion

The political maneuverings of those who would socialize medicine have thus far always featured promises to preserve the patient-physician relationship—whether these avowals are sincere or cynical is beside the question. It is a fact that that which government pays for it must regulate and control. When one regards the nearly 70 pages required to set forth the current legislative proposals and contemplates the flood of regulations that will issue forth in their implementation, the flimsiness of these avowals is properly suspect. When the physician looks upon these samples of federal incursion into the practice of medicine which he has encountered to this date, his own experience confirms what contemplation has suspected. He sees all too clearly that the shackles of inflexible bureaucratic policy do confine and restrict the free operation of this personal factor in the patient-physician relationship. May he not then be forgiven the faintly disrespectful air with which he regards recent assurances that this relationship will not be harmed because, it is said, specific provisions are written into the law to prevent this? Having had some acquaintance with the ephemeral quality of political promises, he has little faith in them.

At this point, it is profitable to review the maneuverings before the public eye in the continuing struggle between this human value and its supporters on the one hand, and the forces for socialization on the other. I hope to demonstrate to you that the repulse of socialized medicine to date has been founded on the strength of this principle and its worthiness in the public mind. At the same time, an examination of the political technics of the proponents of socialized medicine may serve as a gauge of the methods to be employed in the regulation of these programs once in effect. Finally, I must discuss the implications of the present and future political involvement of the medical profession and its cherished principles.

When the first campaign for socialized medicine was unleashed in the form of the Wagner-Murray-Dingell bill, the public position of the profession was one of unassailable respectability. Its scientific knowledge and its clinical skills were praised and its record for public service was admired. In the bitter exchanges which followed, the profession was treated to a hail of verbal abuse. When the A.M.A. countered by appointing a public relations firm to manage its campaign of opposition, it was excoriated by the champions of socialization and by some of its own ivory tower dwellers. Few voices were heard to suggest that the A.M.A. was only doing with its own funds what an army of bureaucratic scriveners was doing with taxpayer funds and presenting its case with the best technical skill available.

Having failed in the frontal assault with national compulsory health insurance, the indefatigable warriors for socialism turned with delight to the Social Security System and the acknowledged difficulties of the aged. There was the need to build up the myth of "insurance," thus capitalizing on a spurious resemblance to that respected American institution; there was the need to convert the system from a retirement program to a disability program, and there was the ultimate need to convert it from an indemnity to a service program. The fact that a series of liberalizations to accomplish this vitiated the original actuarial calculations upon which the system was established as a basic floor of protection. The fact that these produced an under-financed trust was either glibly ignored or happily embraced.

Whipping boy and straw-man—A.M.A.

There stood in the way of the final realization of this grandiose scheme which would reduce all men to numbers, only a few opponents—chief among them the medical profession and its principles. With the aid of a small group of allies, the A.M.A. withstood the challenge of Forand legislation in the face of an enormous pressure bloc armed with

the weapons of patronage and a truly awesome prestige. In view of the fact that the only weapons medicine had in this encounter were reason and logic in defending the value and protecting the freedom of the personal factor in medical practice, the defeat of Forand legislation is truly astonishing.

Unwilling to believe that defeat arose from the validity of a principle, the angered partisans of socialization found it necessary to invent a device which at once served to explain their defeat and as the focal point of the next attack. The arsenals of political warfare shelter devices more diabolic than those of the military, and the folklore of politics numbers its own myths, its witches and poltergeists, its own demonology and its catalogue of saints. Two of its valued devices often are used in conjunction—the whipping-boy and the straw man.

In the current instance, the A.M.A. became the whipping-boy and the myth of its political power the straw man. Artificially constructed and endowed with this mythologic strength they serve as convenient targets and relieve the necessity to assail the image of the individual physician. By design, the targets are portrayed as evil figures standing between an innocent public and its vicariously desired goal of socialization. The indignant urges of the apparently defrauded public will be turned against the villains and pointed past them in the direction of the goal to which this public was previously indifferent. The emotional charge is now laid and the brain-washed public now comes to regard the toppling of the straw man as the final barrier between itself and a reward which it never wanted in the first place. The expected finale consists of a tumultuous mob scene in which the puppets trample the straw man and the whipping-boy to embrace the goal of socialization while lusty voices are raised in song as the triumphant masses are heard in sturdy praise of what? Could it be the "people's democratic government?"

Necessarily, a hatchet man is assigned the duty of hacking away at the supposedly invulnerable straw man. The verbal assaults include the sweeping overstatement, the polemic and the diatribe, and the rationalized misrepresentation, and all are capped with a series of "leaping non-sequiturs." The forms and conventions of this modern morality play may be filled out with the dramatis personae of the cast in the current presentation. The A.M.A. is the whipping-boy and the political power of its 168,000 members is the straw man. The movers for socialized medicine are the heroic saviors of the downtrodden and the role of hatchet man is filled by a succession of resident or itinerant old repertory players.

Attack opponents' approach

The counter moves available to medicine and its allies in preservation of these human values lie in the realm of politics, if politics is used to encompass the whole field of public appeal and debate. The opponents have chosen political routes of attack, and therefore must be met where they approach. There was at one time in my memory, a debate over whether the profession should become involved in politics. That debate was conducted in sotto voce tones, and brief-lived as it was, it escaped the ears of many physicians. It was in any case, a sterile and academic exercise, for medicine was then and is now deeply involved in politics whether it wants to be or not. It will never escape that entanglement for as long as it is free it must fight—and if it should be defeated it will yet need a machinery to preserve whatever rights it can retain and whatever values it can uphold.

Political action is contrary to the nature of most physicians and physicians are quite adept in rationalizing their distaste for such endeavor. But the needs of the day no longer allow such escapism. While the political power of physicians will always be considerably short of the mythologic exaggerations we hear today, such as it is, it should be used intelligently, honorably and to the limit of its capacity. For the enemy consists of that obscure group of men who, by ignorance or by design, would willingly see all of mankind reduced to a multitude of faceless men standing mute and unfeeling as stones in the pervasive spiritual drabness of the perfect socialist state. •

Can hypnosis cont. from page 30

Demerol 100 mg. every four hours for a period of three to four days. Three of the patients in the hypnotic group required only a total of 200 mg. of Demerol, that is two hypos of Demerol, both of which were given in the first eight hours following the operation. None of these had any apparent pain after waking fully from the surgery. Their postoperative recovery was uneventful in every way, they experienced no pain, gas, or any type of discomfort. The other patient in this group followed the sedation and recovery pattern of the control group. That is, the usual postoperative discomfort with gas pains, wound pain, and limitation of diet for three days.

Postpartum course

The response of patients to posthypnotic suggestion in the postpartum period is in many cases almost unbelievable. All have a sense of well-being and of strength, and since hypnosis, there has not been a case of postpartum depression. Episiotomy pain and "afterpains" are diminished and in many cases completely eliminated. The mother goes home in a wonderful frame of mind. It is remarkable how many will say that this baby is the best behaved baby that they have ever had, thus proving that if you have a calm and confident mother the baby usually follows right along and is a calm, quiet, and peaceful child.

The most satisfactory result of the use of hypnosis in obstetrics as far as the attending physician and the hospital personnel is concerned, is the way that these patients conduct themselves throughout the labor and delivery. The typical obstetric patients reach the hospital in labor with fear and apprehension. In the case of many primaparas and some multiparas hysteria is present. Many of these patients are difficult to handle, and some of them refuse to cooperate in the delivery room so that termination of labor is necessarily done under general anesthesia and more or less difficult forceps operations. The typical patients using hypnosis as an aid to their delivery reach the hospital with the posthypnotic suggestion that they will enter a state of hypnosis upon their arrival on the maternity floor in labor. Most patients on their arrival show no evidence of fear, apprehension, or hysteria and are more or less sleepy. After being prepped and put to bed they are cooperative, doing everything they are asked, and if no one talks to them they sleep and relax throughout most of their labor. After the first stage of labor is completed, most of the patients, excepting those in the somnambulistic state, will show some evidence of discomfort and at this time 2 cc. Demerol is given. However, they remain cooperative and will rest and sleep between contractions. In the delivery room this extreme cooperation persists in most cases. The patients will do whatever is requested as soon as they are asked, and will relax and sleep between contractions. In most primaparas, labor is terminated spontaneously or with low forceps under short inhalations of Trilene anesthesia. Most multiparas will have a rapid spontaneous delivery and in almost no case is deep anesthesia necessary.

Conclusions

1. The routine use of hypnosis as an aid to delivery is of great benefit to most maternity cases.

2. Hypnosis can be induced in most patients who elect to use it with a medium state being attained by about 80 per cent, a light state by 10 per cent, and the somnambulistic or deep state by about 10 per cent.

3. The average duration of labor with the use of hypnosis is reduced in primaparas 3.7 hours and in multiparas five hours.

4. The incidence of forceps is not decreased, but deep anesthesia is not necessary for their use under hypnosis and therefore you retain the active cooperation of the mother and do not run the risk of depression of fetal respiration.

5. In those patients needing surgery for delivery, hypnosis is extremely valuable if the medium depth of hypnosis can be obtained.

6. Regardless of the depth of hypnosis reached, it is valuable to all patients during the pre- and postnatal periods and in the course of labor and delivery. •

He needs his muscles working properly—
when they aren't, he needs

Trancopal

How to use *Trancopal*®

Brand of chlormezanone

in musculoskeletal "splinting"

Although "splinting" of a joint by skeletal muscle spasm is often protective, it can go too far or continue too long. Then spasm, pain and disuse may lead to wasting.

When you prescribe Trancopal, you can prevent "oversplinting." Trancopal will relax the spasm, ease the pain and get the muscle working again. Relaxation generally begins within half an hour, and the effects of one tablet last from four to six hours.

In addition to relaxing the muscle, Trancopal will mildly tranquilize the patient, reducing the restlessness and irritability that so often accompany discomfort. With Trancopal, the patient can soon start purposeful exercise and physical therapy.

Trancopal has been found very effective in the treatment of patients with low back pain (lumbago), neck pain (torticollis), bursitis, fibrositis, myositis, ankle sprain, tennis elbow, osteoarthritis, rheumatoid arthritis, disc syndrome and postoperative muscle spasm. Trancopal is available in 200 mg. Caplets® (green colored, scored) and in 100 mg. Caplets (peach colored, scored), bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.

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important tests were those which occurred to house dust, dog, and sage pollen.

Comment

This family lived in a trailer in the yard of the patient's maternal grandparents in the country. There were Pekinese dogs inside the trailer and Pekinese dogs lived inside the grandmother's home. In the interval from the time the child was first seen in late October until the conference was held about three weeks later they had attempted to control the dog situation in a unique manner. The family in the trailer moved into the grandparents' home and the grandparents' dogs were moved into the trailer. This child was very much better in that month. There was very little coughing and he had not had any recurrence of the acute attacks of pneumonia. During this time the baby had been exposed to the dogs for about 20 minutes and this precipitated coughing which lasted several hours.

An allergy program was instituted emphasizing dust control and, by all means, getting rid of the dogs. A report from the family three months later stated the child had not had any further attacks of pneumonia but had had two infections which were relatively easy to control and which were not accompanied by wheezing. Dust injection therapy was not advised because if the family can move back into the trailer and protect the patient from exposures to dogs, an almost ideal inhalant-free environment can be carried out.

It is possible that some of this child's symptoms in August may have been due to late summer pollens such as sage. However, having eliminated one of the building blocks, such as the dogs, and reduced another, such as the dust, it is probable that this child will not have pollen symptoms in the summer of 1960. If he should develop symptoms at a later date coinciding with the spring and late summer pollen seasons, appropriate injection therapy can be started.

Allergic bronchitis. Mrs. B. W., aged 31, was seen October 20, 1959, because of unusually severe episodes of coughing, recurrent attacks of bronchial infections and pneumonia. There were only occasional episodes of wheezing and these occurred with the more severe infections or severe coughing.

This patient is the daughter of a Naval officer and lived most of her early life in coastal areas and much of her trouble was attributed to living in damp climates. In childhood and teenage she had frequent colds and frequent episodes of sinus infection. While attending college she was having unusually persistent coughing but no wheezing. This was, no doubt, aggravated by moderate smoking. Allergy was considered at that time and some allergy testing by the scratch method was done. The tests were essentially negative and no allergy program was advised.

In 1951 this patient married and was living in Germany. While in Germany, she had unusually frequent attacks of pneumonia which were serious enough to require hospitalization about once a month during the winter months. Because of this, she was advised to leave Germany and the family elected to come to Denver because of the dry climate. Unfortunately, the attacks did not subside. She continued to have frequent upper and lower respiratory infections during the winter months but most of these were not severe enough to require hospitalization. Her history was very suggestive of bronchiectasis. Bronchograms were done June 28, 1955, and were found to be normal. Allergy was not reconsidered in view of the previous negative testing. Finally, after having a rather bad time in the winter of 1958-59 with the above symptoms, she was worried about the oncoming winter. Wheezing was now present. The patient obtained moderate relief with the iodides, bronchodilators, and antibiotics.

Physical examination revealed the nasal membranes to be moderately swollen and wet. There was a film of mucopurulent discharge seen on the posterior wall of the pharynx. The patient was coughing considerably but not wheezing. The lungs were clear except for scattered rhonchi.

Intradermal allergy tests were done and the patient developed only a few moderate reactions with the strongest extracts. It is possible that she would have shown no positive reactions by scratch testing procedures. The important reactions were those which occurred to house dust (4 plus) and feathers (3 plus).

Comment

It is interesting that between the time she was first seen in October, 1959, and the conference which was held one month later, this patient and her husband had stopped smoking. In that month she had felt better than she had felt in many years. The coughing had almost completely disappeared. She was not having any of the disturbing nocturnal attacks of severe coughing and wheezing. I feel definitely that this patient has had allergic bronchitis most of her life which was aggravated first with the average amount of smoking and finally by recurrent infections. Symptoms of asthma were slow in developing and were never quite typical of bronchial asthma. After she had stopped smoking she was dramatically improved. I outlined an allergy program to eliminate feathers and house dust. Injection therapy for house dust and feathers was not started since I believe she can remain this well with the simple allergy program outlined for dust. If not, an injection program can be started.

The attitude of the average physician toward early asthma is often one of a casual nature. It was clearly expressed by Urbach

and Gottlieb[3] in 1943. With some slight changes in the wording of this reference I would like to quote: "The great majority of physicians are of the opinion that asthma is not a dangerous disease but it is practically an incurable disease. Although they naturally refrain from expressing this opinion to the patient, the patient very soon senses this pessimistic attitude, which often does immeasurable harm psychically and consequently physically. The physician who is convinced that many cases can be cured and that almost all can be considerably improved, and who is able to communicate this conviction to his patients, possesses the most important prerequisites for success."

Conclusion

Allergic bronchitis occurs frequently and is often a prelude to bronchial asthma. The early institution of an allergy program will provide relief from a sometimes obscure and distressing bronchial "condition." Furthermore, many of these patients can be prevented from progressing on into bronchial asthma. ●

REFERENCES

[1]Hansel, F. K.: Clinical Allergy. C. V. Mosby Co., St. Louis, 1955.
[2]Sherman, W. B., and Kessler, W. R.: Allergy in Pediatric Practice. C. V. Mosby Co., St. Louis, 1957.
[3]Urbach, E., and Gottlieb, P. M.: Allergy, 2nd Ed. Grune and Stratton, New York, 1946.

Editorial cont. from page 25

Heretofore we'd always felt that life began at 40 and considered ourselves young and youthful till at least then. Next came the vast happy middle ground of being middle-aged. Sears has seen fit to do away with middle-age completely. It's like the old joke about the summer season in Maine and Minnesota, "Yessir, we have spring, July 4th, and winter."

Needless to say, we're sadly depressed by it all as we sit here eating breakfast, popping our geriatric vitamins into our mouths, and sucking feebly and half-heartedly on our Testosterone linguets.

WESSON OIL features a
CHOLESTEROL DEPRESSANT DIET COOK BOOK
in their double spread advertisement appearing on pages 38-39 of this issue.

A second printing of "Your Cholesterol Depressant Diet Cook Book" has been issued to fill quantity requests from members of the medical and dietetic profession, it was announced recently by Wesson. Requests for the free manual have been so heavy since its original release a few months ago that some delays in delivery occurred. The newly printed supplies of the booklet will permit prompt response to present and future requests for the booklets.

Features of the Cholesterol Depressant Diet Cook Book include menus, recipes, diet and cooking guidance, all arranged according to levels of 1,200, 1,800 and 2,600 calories per day so that the physician need only check the desired daily calorie level before issuing the book to the patient. Ten complete daily menus provide prescribed levels of calories, the predetermined ratio of poly-unsaturated to saturated fat, and the essential nutrients which are recommended by the Food and Nutrition Board of the National Research Council.

The menus in this diet manual adhere as closely as possible to the patient's normal eating habits. Dietary fat is controlled so that approximately 36% of the total calories are derived from fat, and at least 40% of these are from poly-unsaturated components as found in pure vegetable oil. Along with the cholesterol depressant menus, less rigid cholesterol maintenance menus are offered to help the patient's continued progress after the desired therapeutic results have been accomplished.

Physicians and dietitians may obtain at no cost multiple copies of "Your Cholesterol Depressant Diet Cook Book" by writing to Wesson, 210 Baronne Street, New Orleans, Louisiana.

Temporal Bone Bank *Center*

Although many realize that a Temporal Bone Bank has been established by the Deafness Research Foundation, many doctors will be interested in the strides that have been made by the Foundation in establishing additional units now functioning in leading research laboratories across the country. In January a National Temporal Bone Bank *Center* was launched at the University of Chicago under the direction of John R. Lindsay. Additional information may be obtained by directing inquiries to: Mrs. Hobart C. Ramsey, President, The Deafness Research Foundation, 310 Lexington Avenue, New York 16, New York.

Patterns of Disease

A direct relationship between the quality of a community's water supply and the incidence of diarrheal disease among its residents is noted in the current issue of *Patterns of Disease*, a Parke, Davis & Company publication for the medical profession. Studies reported in the publication revealed that in communities which have a highly contaminated water supply, the incidence of diarrheal disease may be more than 17 per cent of the population. In communities with a relatively pure water supply, however, the incidence drops to 7.5 per cent. Moreover, where the water supply is of low quality, not only is the incidence of diarrheal disease greater, but the illness itself is more severe.

Sanitary facilities are another major factor. Where the level of sanitation is low, the incidence of diarrheal disease is high. In one study mentioned by *Patterns*, "prevalence of infection with Shigella was more than five times greater in families having a privy and water outside the dwelling than in those having sanitary facilities in the home."

Common sense cont. from page 36

criticism of fellow therapists provides a barrier to keep professional and public opinion healthy. A few extra hvl of common sense may prevent injury to professional health by the Au^{197} radiations.

Epithets

Common Sense, allied with Science and Logic, is forever at war with Prejudice, which, for its support, has first call on Epithet. It is generally more acceptable to employ Epithet against things (apparatus) than against persons (other therapists).

The outstanding generators of prejudice are novelty and costliness. To the possessor of new, expensive therapy apparatus all others "have to be economical, of course," and are "stuck with old-fashioned, or outmoded equipment," because there isn't any "cheap" way to get "adequate quality." The have-nots, of course, say that they don't go for the "new-fangled stuff." They believe that their "conventional" technics are "dependable" or may even call them "tried and true." I am not claiming myself to be immune to such sentiments. In 1929, at Pasadena, I predicted that their 500 kv x-ray would not prove much more effective than our 200 kv "deep therapy." Immediately afterward I thought I saw a way within our means to achieve 400 kv, and took off after it.

The choice of radiation therapy should be based on a cool estimate of all considerations. Knowing that other equipment may be more powerful, one has to decide whether one's own equipment is sufficient. Knowing one's own competence, is it likely that someone else's competence will be superior in critical degree for this particular patient? One must remember that, by definition, there is only one "best" therapist, and that that one man cannot take care of all the patients.

Referral and confidence

To refer, to consult, or to go ahead—which is wisest? The decision rests on the therapist's confidence in himself and the patient's confidence in the therapist. With confidence on both sides, of course, one goes ahead. If you haven't got the patient's confidence, maybe you should not be treating him, however able you may be. Consultation will reveal perhaps that the patient is unable to give any physician his confidence. Then, in all charity, you should continue to treat him if he will have it; and in all common sense you should have consultation for every decision and a witness for every treatment.

Sometimes a patient decides to chuck a therapy that is going badly (true or not) and go to another therapist or "to the Mayo Clinic." An exhibition of vanity on your part will only hurt his feelings and your reputation, without dissuading him.

Quacks

Most disturbing is the one who decides to try unorthodox therapy. One's charity and one's common sense are strained to the utmost. One would have to be very sure of the good one expects to do for the patient before one would venture to bring much pressure to make him stay with present program. One should, of course, dutifully and quietly explain how the place where he is going looks to the medical profession. One should quote factual data if they are available. But one does not expect to change the patient's mind. No good to rail at the unconscionable quack, and positive harm to complain about the ungrateful patient. If his acceptance of the quack's promises is not dispelled by gentle debunking, it will usually be found to resist the fiercest attack that you can make. Guided by your common sense, then, you do your unhappy best to smooth his path. If you have not closed his mind by making him resist your too vigorous attack, he will perhaps, himself, see through the quackery and return later to your care. It is seldom that such an adventure does great harm, because ordinarily those who leave one's care are only those for whom "our deep plots do pall."

Consultation

Consultation is costly for the patient and a strain on the mind and feelings of the physician. It should not be asked for lightly, but only for good reason. It has seemed to me that these reasons are too often not recognized—or wilfully not seen. One should always accede to the patient's request for consultation—this seems obvious; or if one

suspects that the patient has been deterred from asking. I am amazed how many fear that it is unethical—as if professional ethics bound the patient! Sometimes a patient fears that to suggest consultation will enrage his doctor. Might be, you know, but a physician should have his vanity in harness.

The more skillful and tactful the therapist, the more confidence his patient will have in him. Then any consultation will be not because of the patient's apprehensions, but rather by the therapist's common sense. It should be obvious that the responsibility is not comfortably carried all alone in a case that turns out badly. It is characteristic of cancer that most cases are not cured. For many a patient and his relatives the bad outcome arouses a vivid doubt of the therapist's skill and maybe of his proper attention to the case.

In more instances, perhaps, it is the therapist's uncertainty, rather than the patient's doubt, that calls for consultation. If surgery could well be chosen instead of irradiation, or if someone might think it could be, then consultation should be had before any treatment is begun at all. What can be more frustrating than to be called to help make a decision when in fact the decision has already been made, and the course of therapy is half done? Unless it be to have brought to one a patient never before seen, who has had her tumor cut out, the surgeon asking to have one cure (easily) the little cancer that may have been left behind. In either case, if one thinks the treatment should have been different, it is too late to change it, and for the patient's peace of mind one must agree that the further treatment planned is exactly right. In any case, if a consultation can be smelt, however far away, demand it now!

The Three Graces

On a small table in my grandmother's parlor stood The Three Graces, in white marble, from Italy—Faith, Hope and Charity. I was told: "The greatest of these is Charity." With all charity let us view the therapist's necessity to believe that he is doing good work and that his machine is capable of carrying him in the forefront of progress. Faith is essential—faith of the patient in his physician, and faith of the physician in himself.

But for the cancer patient Hope stands first. Fortunate it is that Hope (like Truth) crushed to earth doth rise again. Many a cancer patient ultimately arrives at a stage where cure is obviously impossible. Hope, by then, has no common-sense basis left in fact. Yet somehow the patient's hope must be upheld. If no promise, even of palliation, can be wrung from surgery or hormones or chemotherapy, then palliative irradiation should be discussed again. Almost always a program of therapy can be found that promises some local improvement visible to the patient, without adding to his discomfort. These are the times when one must remember: "The physician should at least do no harm," and again: "It's just not common sense to achieve palliation by making the patient miserable."

Supervolts and megavolts

I count myself among the early skeptics of the cancerocidal efficacy of a million volts. I had the temerity to parade my skepticism before physicists of great stature. Physicists have been generous in teaching me ever since—whenever the matter was within my ability to grasp it. For all my skepticism about the qualitative superiority of energetic quanta for selective annihilation of cancer cells, still one must see that megavolts enable one to put the radiation into the chosen portion of the body's interior more nearly according to one's therapeutic wishes, than with only kilovolts. Inasmuch as we have not yet learned to teach radiation much histological discretion in its attack on living tissues, it must be obvious that topological limitation is an essential part of the therapeutic art. Common sense will tell one not to use a cumbersome multi-megavolt machine costing multi-megabucks for the placement of therapeutic dosage that can be accomplished with less effort using a lighter, more flexible, quarter-megavolt machine. However, unless the therapist has the megavolt machine available he can hardly be certain that his decision is dependable—that 200 kv is on the whole to be preferred for

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this particular patient. There is a good historical illustration in the heartfelt debate that raged at one time over the relative therapeutic value of constant potential versus rectified a.c. The physicists showed that the hvl was just as good from 160 kvcp as from 200 kvp. Yet one knew for sure that the latter provided some radiation of larger quantum energy than the former did. Common Sense was unable to make itself heard in this debate until 400 kv machines became available. The smallness of the observed clinical difference between hvl 6 mm Cu and 1 mm Cu finally convinced the disputants that there was no sense straining at half millimeter differences. More recently the manufacturers have managed to submerge common sense again by their vigorous competition at 250 kv constant potential.

The therapist cannot keep himself convinced that he is able to do his best unless he has not only megavolt radiation but also intracavitary and interstitial sources readily available, besides the 200 kv or 250 kv apparatus that has come to be considered "standard deep therapy"—the wheel-horse of the team. The megavolt gamma rays from Co-60 are as penetrating as the filtered bremsstrahlung from a 3 megavolt accelerator. Irradiators for Co-60 teletherapy are available that are as safe and flexible as the megavolt x-ray machines and not far different in price. The larger exposure rate available in three-megavolt machines is no great attraction. Common sense tells me that there is no great advantage in cutting two minutes off the exposure time when the present treatment times are not times of waiting with folded hands, but are filled up with record keeping, calculations, etc.

It is not possible, I think, to give a worthwhile opinion on the clinical value of the bremsstrahlung from 6-megavolt linac or 20-megavolt betatron. Clinical and biological experiments continue. Common sense tells me to expect nothing revolutionary.

Electrons

The clinical value of 30-megavolt or 50-megavolt electrons is highly thought of by a few doughty pioneers. Even 15-megavolt electrons are being extensively used by one that I have talked to. Obviously these radiations of sharply limited depth of penetration can give dose distributions impossible to achieve by other means. I've yet to learn how many cancers can be brought into the curable category by the betatron. Common sense bids me still to keep my eyes on the small difference between the tissue dose that kills cancer and the dose that kills the normal tissues that the cancer is embedded in.

The scattered beam of high energy electrons from a multi-megavolt accelerator, reduced to average energy of a few Mev, has proved excellent in a few cases of very widespread dermal disease, notably in mycosis fungoides. Limited areas of the skin can be efficiently irradiated with flat beta-ray sources. Examples are the Sr^{90} ophthalmic irradiator, and, for larger areas, P^{32} absorbed in blotting paper.

The irradiator

We have learned the art of external irradiation through half a century's experience with x-ray tubes. We have shown great inventiveness in apparatus and great resourcefulness in devising technics to give the desired tissue doses to the regions where we want them. We have escaped the tyranny of the skin reaction and can turn our therapeutic judgment to the relative hazards to the normal tissues *inside* the body. The preservation of the integrity of the skin once loomed very large. For many years the usual chosen tumor dose was just however much the tumor had absorbed by the time the skin had got all that it was safe to give.

The dermal barrier has been by-passed in two ways: 1. Megavolt radiation that delivers the maximum absorbed dose a millimeter or so beneath the surface instead of in the cuticle. 2. Rotation therapy or multiportal applications more carefully carried out. These continue to be done with a single source (x-ray or gamma ray).

It seems our minds are in a rut. We are unable to grasp the opportunities presented by the ready divisibility of a radioactive source. Multiport and moving beam therapy are achieved by dividing the exposure in time and applying the pieces seriatim. The same result could be achieved by dividing

the exposure in space and applying the pieces simultaneously. History has a few examples of the simultaneous use of two x-ray tubes. But what I'm thinking of is very many sources for simultaneous cross-fire. Multiple irradiators have in fact been designed. Ellis proposed to surround the patient with a circle of Co-60 sources, each with its collimator, all directed to the same central location. One is actually in use (Quick's). This employs a ring of radium sources collimated so that the useful beams come together at the apex of an obtuse cone.

The advantages of multiple source irradiation are several: 1. The perfect coincidence of all the cross-fire beams is assured. 2. The source-to-tumor distance can be short, just so the machine does not press too close upon the patient. This increases the efficiency of use of the radioactive nuclide. 3. Subdivision of the source obviates the losses due to self-absorption and permits one to make the sources physically small. This reduces the penumbra (gives the useful beams sharp edges).

There is a disadvantage in that each small source requires its own enclosure to protect people from radiation. This means a much less efficient use of shielding material. However, lead is cheap.

One would choose the number of sources according to whether one decides to irradiate a wide belt or a narrow one, and full circle or only half circle. The number is limited by the size of the collimating cones, which have to be long enough to provide a sufficient thickness of lead, and wide enough to cover the largest tumor that one contemplates irradiating. For Co-60 sources, which require some 12 cm. of lead shielding, a wide belt, half circle, can use 96 sources. A large single source of Co^{60} must have a diameter of a centimeter or more if it is not to be so thick as to lose most of its radiation through self-absorption. Cs^{137} sources have even more self-absorption, and are being made an inch or more in diameter in clinical irradiators. Divided into 200 sources (Cs^{137}), each would be about 3 mm. in diameter.

Summary

The therapist needs not only science but experience. He has to supply some necessary understanding of disease and therapy to the patient he is treating. He has to take the patient's personality as he finds it. He is fortunate if the patient has some common sense.

The therapist has need to forestall some ready misconceptions and sentimental aberrations in himself. He has to keep his pride and his ambition in check while making difficult decisions about his own competence to treat a given patient, about referrals and consultations, and about the management of patients for whom little or nothing can be done. He must resist being too much swayed by impressive figures in megavolts and megabucks. He must avoid giving value to differences in quality, output and depth dose distribution that are so readily measured by a physicist and yet imperceptible to a clinician. He must listen to the facts that underlie the exaltation and the derogation by epithets, carelessly or purposefully applied. His major tool for accomplishing these ends is common sense.

Beams of radiation are today available for external application that permit one to give the desired deep dose without destroying the overlying skin. Rotation therapy can achieve this without using radiation of extreme quality. "Rotation therapy" without rotation could be accomplished with gamma rays by subdivision of the radioactive isotope into multiple sources, separately collimated.

Beta ray therapy is useful for superficial lesions. High energy electron beams with their delimited depth of penetration can do some things that gamma rays and bremsstrahlung cannot do. •

SELECTED READING

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Cancer quackery: L. H. Garland, The Pursuit of the Unorthodox, Journal of Michigan State Medical Society 57:525-531, 1958.

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Rotation therapy sine rotation: F. Ellis and R. Oliver, a design for a 2,400 curie Co-60 unit for radiotherapy, Radioisotope techniques 1:1-8, in Proc. Isotope Techniques Conference, Oxford, July, 1951, H. M. Stationery Office.

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American Fracture Association Meeting, Washington, D. C.

The 22nd Annual Meeting of The American Fracture Association will be held September 16 through September 23, 1961, at the Shoreham Hotel, Washington, D. C. Acceptable for Category No. 2 by the American Academy of General Practice.

Postgraduate Course in Orthopedic Surgery and Fractures—Georgetown University School of Medicine, Gorman Auditorium, Washington, D. C., Sunday, September 17, 1961. Acceptable for Category No. 1 by the American Academy of General Practice.

For further information regarding this meeting, contact Program Chairman M. C. Cobey, M.D., American Fracture Association, Washington, D. C.

Early fall lectures scheduled

Early fall lectures presented by Continuing Education in Medicine and Health Sciences, University of California Extension, open with "Obstetrics and Gynecology," September 14, Medical Sciences Auditorium, U.C. Medical Center, San Francisco. This symposia will emphasize problems of infertility, diagnostic methods, vaginitis, prenatal care, useful drugs, urinary tract problems in women, and menstrual disorders. Principal speakers are Drs. John I. Brewer, E. Stewart Taylor and Edward T. Tyler, noted authorities in the field.

Other programs include: "Internal Medicine—A Selective Review," September 18-22; "Neuropsychiatry in General Practice," September 28-November 2; "A Clinic on Human Disabilities," September 29-30; and "Evening Lectures in Medicine," covering problems faced by the physician in practice, October 3-November 28.

Other conferences scheduled for fall are: "Bone: Clinical Application of Recent Advances;" "Urology;" "Problems Due to Infection in Medicine and Surgery;" "Problems of Adolescence;" "Alcohol and Civilization;" "Psychiatry in General Practice;" "Surgery of the Hand and Forearm;" and "External Diseases of the Eye."

For further information on these programs, write Continuing Education in Medicine, University of California Medical Center, San Francisco 22, California.

Thirteenth Postgraduate Assembly in Endocrinology and Metabolism

The Thirteenth Postgraduate Assembly in Endocrinology and Metabolism, under the co-sponsorship of The Endocrine Society and The National Institutes of Health, will be held in Bethesda, Maryland, October 2-6, 1961. A comprehensive review of clinical endocrine problems and current research activity in these areas will be presented. For further information, write to: Dr. Roy Hertz, National Institutes of Health, Building 10, Bethesda 14, Maryland. The fee will be $100.00 for physicians, with a reduction to $30.00 for Residents and Fellows. Enrollment limited to 100.

The Society of Nuclear Medicine

The Society of Nuclear Medicine recently concluded its Eighth Annual Meeting in Pittsburgh, Pennsylvania. Approximately 500 physicians and other scientists from the United States of America and other countries were in attendance at this meeting, where over 80 papers were presented.

Prof. George C. de Hevesy of the University of Stockholm, Sweden, winner of the 1943 Nobel Prize in Chemistry and the second Atoms for Peace Award in 1959, presented the second of the Annual Lecture Series—a series of lectures dedicated to pioneers in nuclear medicine—in honor of Marie and Pierre Curie, and Henri Becquerel.

The following officers were elected:

President: Linden Seed, M.D., Chicago, Illinois.

President-Elect: J. R. Maxfield, Jr., M.D., Dallas, Texas.

Vice President: Herbert C. Allen, Jr., M.D., Houston, Texas.

Vice President-Elect: Joseph Sternberg, M.D., Montreal, Canada.

Secretary: Robert W. Lackey, M.D., Denver, Colorado.

Treasurer: William H. Beierwaltes, M.D., Ann Arbor, Michigan.

Historian: Asa Seeds, M.D., Vancouver, Washington.

The following were elected as members of the Board of Trustees for three years:

William J. MacIntyre, Ph.D., Cleveland, Ohio; David I. Livermore, M.D., Washington, D. C.; Sydney F. Thomas, M.D., Palo Alto, Calif.; Clarence C. Lushbaugh, M.D., Los Alamos, N. M.; Sylvia O. Fedoruk, M.D., Saskatoon, Saskatchewan, Canada; Robert Harry Rohrer, Ph.D., Atlanta, Ga.; R. E. Ogborn, M.D., Omaha, Nebr.; D. A. Ross, Ph.D., Oak Ridge, Tenn.; Thad Sears, M.D., Denver, Colo.; Frank Norton, LL.B., Dallas, Texas; Y. T. Oester, M.D., Chicago, Ill.

The Ninth Annual Meeting of the Society of Nuclear Medicine will be held at the Baker Hotel, Dallas, Texas, June 27-30, 1962.

WANT ADS

WANTED: GENERAL PRACTITIONER as an associate, in well established practice in busy southern Colorado city. Excellent fully accredited hospitals. Skiing, hunting and fishing within the immediate area. Salary open. Reply Box 8-1-3, Rocky Mountain Medical Journal, 835 Republic Building, Denver 2, Colorado. 8-1-3

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PEDIATRICIAN—Ten-man Montana group in need of second pediatrician, certified or board eligible. Start at $15,600. Annual increases. Partnership interest after first year. Reply to Box 8-8-3, Rocky Mountain Medical Journal, 835 Republic Building, Denver 2, Colorado. 8-8-3

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NEVADA: Senior Psychiatrist. Salary: Range A—Up to $15,408, requires graduation from approved school with one year internship and five years psychiatric experience or residency approved by the A.M.A.; Range B—Salary: up to $16,980, requires same as Range A plus certification by the American Board of Psychiatry and Neurology. Current vacancies exist at the Nevada State Hospital in Reno and in the Community Health Program in Las Vegas. This provides an excellent opportunity for someone desiring location in the center of a recreational and sports area featuring skiing, hunting, fishing, etc. Apply: State Personnel Department, Carson City, Nevada. 7-4-TF

PHYSICIAN WANTED: New Mexico G.P. or Internist to lease new, air-conditioned, fully equipped office of deceased G.P. in rapidly growing city of 27,000. Modern, open staff hospital. Box 624, Clovis, N. M. Telephone POrter 3-5255 7-5-TF

WELL EQUIPPED HOSPITAL, backed by funds from the Walsh Hospital District. Any doctor interested please contact Daryl Walker, Mayor of Walsh; Clarence Burson, chairman of the Walsh Hospital Bd. of Directors; A. R. Lussier, Banker, or Dr. E. B. Blease of Baca County Medical Center, Springfield, Colorado. 6-4-3

NEVADA COMMUNITIES seeking physicians include Wells, Carlin, Austin, Beatty, Pioche, and Hawthorne. Write Mr. Nelson B. Neff, Executive Secretary, Nevada State Medical Association, P.O. Box 2790, Reno, Nevada, for further information regarding these opportunities. 5-TF

INTERNIST COMPLETING RESIDENCY July 1, 1961, desires association with group or individual in Colorado or Rocky Mt. area. Reply Box 5-3-TF, Rocky Mountain Medical Journal, 835 Republic Bldg., Denver. 5-3-TF

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MEDICAL TECHNOLOGIST with some x-ray training; small clinic; $350.00 month; 5½-day week; skiing, fishing, outdoor area. Box 4-2-TF, Rocky Mountain Medical Journal, 835 Republic Bldg., Denver, 4-2-TF